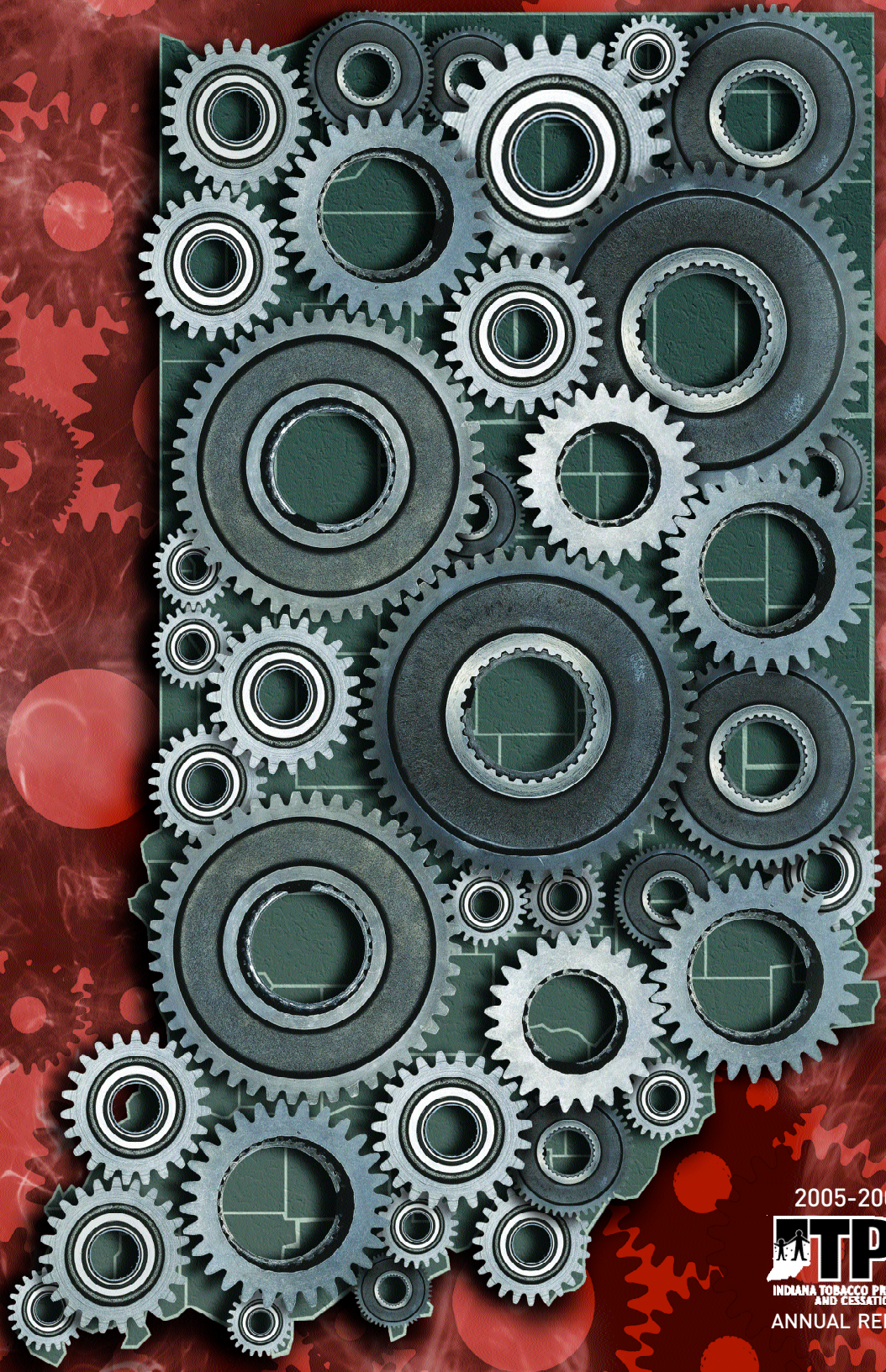
TOBACCO-FREE WORKS

GETTING IN GEAR FOR A HEALTHIER INDIANA



2005-2006

ITPC

INDIANA TOBACCO PREVENTION AND CESSATION

ANNUAL REPORT

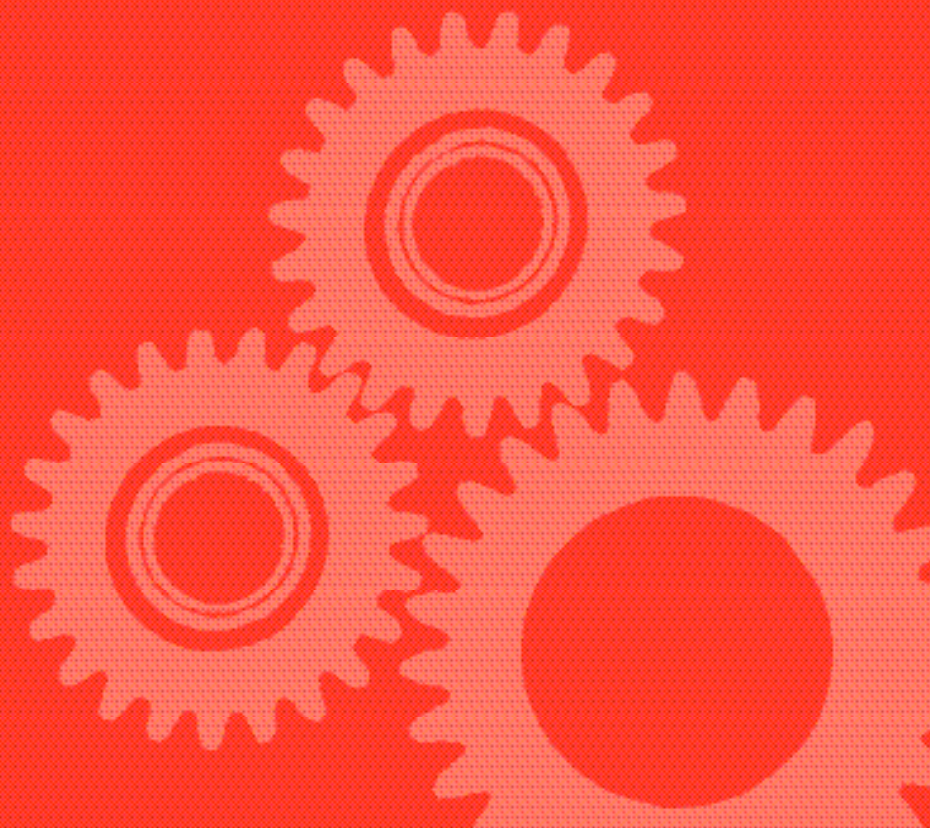


Table of Contents

Greetings from the Executive Director

Karla S. Sneegas, M.P.H.

In January of 2006, more than 40 years after the first Surgeon General's report on "Smoking and Health" first warned Americans of the serious health risks of cigarette smoke, Governor Mitch Daniels delivered the sobering news that Hoosier health is in bad shape—causing a human and economic blow to our state.

As part of his State of the State Address, Governor Daniels said it was time for Indiana to move on health initiatives.

In his speech, Governor Daniels said,

> *"...It's a troublesome truth that ours is one of the least healthy states in America. We weigh, drink, and smoke too much, and exercise too little. So it's no accident that we have some of the highest health care costs anywhere, a barrier in the way of the new jobs we seek.*
>
> *"Our InShape Indiana initiative is off to a reasonable start, with thousands of citizens signing up to pay more attention to basic principles of wellness. But no single step we could take would matter more than reducing the percentage of Hoosiers, particularly young Hoosiers, who smoke cigarettes"*

Tobacco use is still the number one preventable cause of death and disease in Indiana.

More concerning, recent progress in reducing adult smoking rates has stalled following past dramatic funding cuts to tobacco prevention and cessation programs. Data from the 2005 Indiana Behavior Risk Factor Surveillance System survey show that Indiana's adult smoking rate increased from 24.9 percent in 2004 to 27.3 percent in 2005; this figure represents a troubling reversal from just two years ago when the smoking rate declined from 27.7 percent in 2002 to 24.9 percent in 2004.

Meanwhile our Eastern neighbor, Ohio, funds comprehensive tobacco reduction programs near the recommended levels established by the Centers for Disease Control (CDC). They also recently increased their cigarette tax. Their actions have paid off--Ohio's smoking rate went down dramatically from 27.7 percent in 2001 to 22.3 percent in 2005.

Ongoing progress in Indiana:

In his state of the state address, Governor Daniels called on the Indiana General Assembly to increase Indiana's cigarette tax, the lowest in the Midwest. Governor Daniels said, "All the evidence shows that the most effective way to deter young smokers is at the cash register". He asked the General Assembly to raise Indiana's cigarette tax by at least 25 cents a pack. While the tax initiative did not pass last session, there is renewed interest and continued discussion in this proven strategy for reducing youth and adult smoking.

Healthier communities for Hoosiers:

In June of 2006, the U.S. Surgeon General once again issued a landmark report, this time on secondhand smoke. U.S. Surgeon General Richard Carmona said,

> *"The scientific evidence is now indisputable: Secondhand smoke is not a mere annoyance. It is a serious health hazard that can lead to disease and premature death in children and nonsmoking adults...Smoke-free environments the only approach that effectively protects nonsmokers from the dangers of secondhand smoke."*

Indiana communities are already answering the Surgeon General's warning.

- In the past 18 months, 21 cities and counties passed smoke-free air laws that deliver basic health protection from secondhand smoke to workers and citizens. This is a breath of fresh air for our lungs and the economic outlook of Indiana.
- Governor Mitch Daniels directed the Indiana Department of Administration to develop a policy for Indiana's downtown state government complex to become 100% smoke free on January 1, 2006.
- In May, IUPUI's Chancellor announced that the entire campus would become 100% tobacco-free when students returned in the fall. IUPUI is the first major urban university campus in the country to make such a move signaling that the 100% tobacco free campus concept that is working for Indiana's public schools and hospitals is migrating to higher education.

Building for long-term solutions:

The painstaking process of setting up a strong infrastructure for tobacco control is paying off as local attitudes and policies are changing. The ITPC network of local, minority and state partnership grantees continue to impact communities statewide.

- Through the network of 110 ITPC affiliated-grantees, over 2,100 local community organizations are working to fight tobacco use and conducted over 5,750 activities last year.
- Hoosier attitudes continue to change through the Whitelies.tv and Voice public education campaigns. For example, youth with awareness of Voice are 13 times more likely to have strong anti-tobacco attitudes.
- The ITPC Executive Board adopted the second long-term strategic plan for reducing tobacco use after an extensive planning process that began in the Fall of 2004.

Continued Tobacco Industry Impact

In contrast to Indiana's reduced funding in its fight to stop smoking, the tobacco companies have increased the amount of marketing dollars they spend in Indiana and are introducing new addictive products that thwart our efforts.

- Tobacco industry spending in Indiana increased to a record $475 million, amounting to 44 times what the state invests in programs to prevent kids from smoking and help smokers quit.
- Tobacco product marketing, since the settlement between the attorneys general and tobacco industry, has shifted drastically to young adults ages 18-24. Indiana's rate of smoking among this age group increased from 28.2 percent in 2004 to 39 percent in 2005.
- Nicotine levels in American cigarettes are steadily rising, increasing their addictive properties.
- Central Indiana was a test market for a new smokeless tobacco product, marking the second time in five years that Hoosiers became guinea pigs for addictive tobacco products. This further damages Indiana's image as unhealthy.

There is reason for great hope as we prepare for another year of hard work. The many people and community organizations that have worked hard and long to make Indiana a healthier place now have the focus of the whole state and its leaders. Now is the time to seize a rare opportunity, not just for short-term progress, but to put in place the programs and policies that will improve the health of Hoosiers and the state economy for generations to come.

Reversing Indiana's troubling tobacco use rates requires us to stay the course. The recipe for our future success is simple: Continue to apply scientifically proven strategies for tobacco use reduction with enough resources to get the job done.

Executive Summary

Tobacco free works in Indiana! Hundreds of state organizations and local community coalitions of health care professionals, schools, businesses, faith communities, youth and citizens are passionately working for a tobacco free Indiana. They want all Hoosiers to live healthier, tobacco free lives. Unfortunately, tobacco is still the leading cause of death and disease in Indiana, killing 27 Hoosiers every day. Exposure to secondhand smoke is the third leading cause of preventable death. For every eight smokers that die from tobacco use, one nonsmoker dies from exposure to secondhand smoke.

Each year in the United States, an estimated 50,000 deaths are attributable to secondhand smoke breathed by nonsmokers. These deaths are due to heart disease, lung cancer, and sudden infant death syndrome (SIDS). In Indiana, each year 950-1,690 Hoosiers die from others' smoking, such as exposure to secondhand smoke or smoking during pregnancy.

In SFY 2006, Indiana received troubling news of the reversal of the smoking decline among adults, as 2005 data show an increase in the adult smoking rate to 27.3 percent. This increase is not a surprise because in Indiana the tobacco industry outspends tobacco prevention programs 44 to 1. In addition, for the third year, funding for such programs to prevent youth from starting and helping adults quit smoking have been funded at 69 percent below the minimum level recommended by the Centers for Disease Control and Prevention (CDC).

The Indiana Tobacco Use Prevention and Cessation Trust Fund and Executive Board exists to prevent and reduce the use of all tobacco products in Indiana and to protect citizens from exposure to tobacco smoke. Following the Centers for Disease Control (CDC) Best Practices for Tobacco Control, Indiana established a tobacco control program that is coordinated, comprehensive and accountable. The Hoosier Model for tobacco control incorporates elements from all nine categories recommended by the CDC and has five major categories for funding. The Hoosier Model consists of Evaluation and Surveillance; Community Based Programs; Statewide Media Campaign; Enforcement; and Administration and Management.

Highlights in the Report:

- Youth smoking among high school students decreased 32 percent from 31.6 percent in 2000 to 21.3 percent in 2004, while middle school youth smoking is at 7.8 percent, a decline of 20 percent from 2000. Youth smoking rates are below the national rates for the first time.

- The smoking rate for adults increased to 27.3 percent. This troubling data shows the reversal in the decline of smoking among adults from 27.7 percent in 2002 to 24.9 percent in 2004, indicating a trend in the wrong direction and a reduction in programming due to budget cuts. Data from sub-populations are also a serious concern, as young adults (ages 18-24) and Hoosiers without a high school education have alarmingly high smoking rates.

- Consumption of tobacco products increased 3 percent in SFY 2006 from the previous year. The dramatic decrease in consumption occurred between SFY 2002 and SFY 2003 due to the tax increase of 40-cent increase that took effect in SFY 2003. The impact of

the tax on cigarette consumption has slowed since SFY 2003, as Indiana's tax is lower than the current average cigarette tax for all states is 95.3 cents. State revenue collected has increased by 189% since SFY 2002.

- Indiana has experienced an amazing level of local smoke free air ordinance activity during the past year. As of June 30, 2006, 23 communities had passed some local smoke free air law . More than one-third (36%) of all Hoosiers covered by one of these 23 local communities laws, an increase from 3 percent in 2000.

- The Americans for Nonsmokers' Rights recognized Indiana as the state with the third most local smoke free air policies passed in 2005.

- State tobacco control partners developed the "Fundamentals for Smoke Free Air Policy Development for Hoosier Communities", based on the national model. The Fundamentals are recommended guiding principles for developing and implementing effective smoke free policies that help achieve the goal of saving people's lives from the disease and death caused by secondhand smoke.

- Hospitals and health care facilities are leading the charge and setting the example in their community. In 2005, 36 facilities went smoke free on hospital grounds, another 30 hospital and major health centers implementing tobacco free campuses in 2006, and so far eight campuses are scheduled for 2007.

- Over 400 participated in the largest training initiative, the Indiana Tobacco Control Partner Information X-Change, "Looking Forward to the Tobacco Free Indiana" on March 1-2.

- Eighty-eight of Indiana's 92 counties received a grant to conduct tobacco prevention and cessation in their communities, including setting up resources to help smokers quit. Over 2,100 organizations are involved locally, including 15 local and state minority organizations and seven organizations working on statewide programs.

- ITPC local partners have conducted over 5,750 local program activities ranging from VOICE events to community presentations to training. Partners are implementing prevention and education programs in schools, developing cessation networks, working to protect Hoosiers from secondhand smoke, engaging local businesses in tobacco free efforts, and raising awareness of tobacco prevention activities.

- Six regional Voice Hubs provided ongoing technical assistance for local adults and youth on youth advocacy and how to build and sustain 53 local Voice movements.

- Over 3,500 calls came in through the Indiana Tobacco Quitline from March 22 to June 30, demonstrating the great need for this service to help Hoosiers quit smoking.

- Three out of four Hoosier adults recall at least one ITPC anti-tobacco advertisement. Sixty-nine percent of adults could recall at least one television ad. Eighty percent of young people in Indiana confirmed they saw at least one ad, based on data in July 2005.

- A strong majority (88 percent) Hoosiers believe that tobacco companies should have not have the same rights as other industries to market their products.

- More adults strongly agreed that secondhand smoke is a serious problem, representing an increase to 38.5 percent in 2005 from the baseline findings of 30 percent in 2001.

- Youth with confirmed awareness of Voice were 13 times more likely to think that smoking is not cool or that smokers do not have more friends; and were twice as likely to know the dangers of tobacco use.

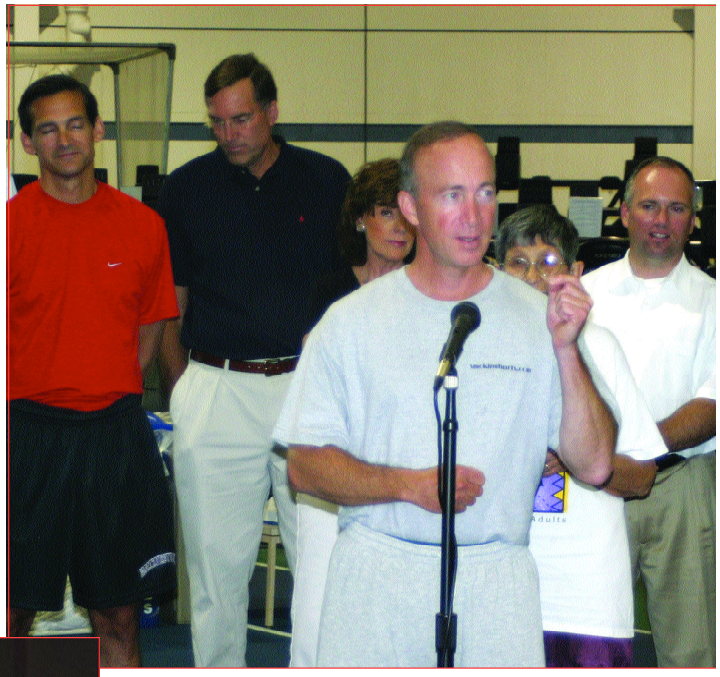
- WhiteLies.tv and the Voice movement had a significant presence Indiana Black Expo's Summer Celebration through the WhiteLies.tv free concert; the exhibit at the Indiana Black Expo information center, and exhibit space within the health fair to distribute materials regarding the dangers of second-hand smoke and tobacco cessation.

- Nearly 300 teens and 50 adults participated in ACT 2005, Indiana's Voice youth summit. The youth created, coordinated and implemented a "drop", signifying the number of Hoosiers killed, or "dropping dead," each day by tobacco use. Youth were then equipped to go back into their local communities and create similar events that would culminate in a statewide "Drop Dead Day" in May. More than 500 youth in 45 cities from around the state participated in staged events of Drop Dead Day during the first half of May.

- Indiana generated 3,200 newspaper clips, mostly on the topics of secondhand smoke, health consequences, coalition partner activities and cessation. Five counties logged over 100 clips. All of these counties had a smoke free air ordinance campaign at some level during this past year.

- Tobacco Retailer Inspection Program officers conducted more than 7,500 inspections of retail tobacco outlets, averaging over 625 inspections per month. TRIP enforcement activities have resulted in sales rates to youth of less than 10 percent.

1 As of August 28, 2006, 26 communities are smoke free (adding Zionsville, Greensburg, and Kokomo). Eighteen of the 26 are strong public health policy and follow the guidelines outlined by the U.S. Surgeon General in eliminating exposure from secondhand smoke from the indoor places that the respective ordinances covers.



Indiana's Tobacco Control 2010 Strategic Plan

In 2001, the ITPC Executive Board established a set of 19 measurable objectives to be achieved by 2005. Programs such as the community grants, the public education campaign, and enforcement efforts were designed to effect changes that will promote one or more of the 2005 objectives. Thus the objectives were a guide to programs initiatives and spending, they also guided the evaluation, data collection efforts, analysis and reporting. Previous annual reports provided current measures on these 19 objectives. In transitioning from the 2005 strategic plan to the 2010 strategic plan, many of the objectives will be continued but others have been added and refined to reflect the 2010 plan.

ITPC staff began the planning process for the 2010 Strategic Plan in the Fall of 2004 with an environmental scan of existing state health related plans that include a tobacco prevention and cessation component. Focus groups and key informant interviews were conducted at the national, state, and local levels. These interviews included tobacco control experts, local health and hospital administrators and large employers in each county of the State. In addition, input was gathered from local ITPC affiliated coalition coordinators. Throughtout the year, the State Partners Network on Tobacco Control, facilitated by Smokefree Indiana, developed strategies and tactics specific to a statewide cessation plan. This plan was incorporated into the Indiana Tobacco Control plan. National organizations provided advice on setting priorities and the Centers for Disease Control and Prevention (CDC) consulted on the selection of measures and indicators, as well as objective setting.

In November 2005, the ITPC Executive Board approved the six priority areas. Effective strategies for each priority were identified from Centers for Disease Control and Prevention (CDC) Best Practices for Tobacco Control, the Task Force on Community Preventive Services on Tobacco, state and national research, and input from key state partners. The ITPC Executive Board adopted the plan's strategies in February 2006. ITPC staff outlined a list of tactics for each priority area and sought input from ITPC affiliated coalition coordinators to focus the list of effective activities. In the spring of 2006, ITPC staff reviewed the current form of the plan with statewide non-governmental organizations and state agencies for support and collaboration. Commitment forms and endorsements from these groups are being gathered. It is expected that this list of collaborating partners will grow throughout 2006 and leading to 2010.

Philosophy

To achieve behavior change that supports the nonuse of tobacco, communities must change the way tobacco is promoted, sold, and used while changing the knowledge, attitudes, and practices of young people, tobacco users, and nonusers. Effective community-based tobacco control programs involve people in their homes, work sites, schools, places of worship and entertainment, civic organizations and other public places. Evaluation shows that funding local programs produces measurable progress toward statewide tobacco control objectives. The changes in social norms are the result of both prevention and cessation interventions and are best accomplished through a combination of community action and improved public health policy.

The ITPC Executive Board, in the 2000 Senate Enrolled Act (SEA) 108, was charged with the coordination of state efforts to reduce tobacco use in Indiana.

Sec. 11. (a) The executive board shall develop:

... (2) a long range state plan, based on Best Practices for Tobacco Control Programs as published by the Centers for Disease Control and Prevention, for:

(A) the provision of services by the executive board, public or private entities, and individuals to implement the executive board's mission statement; and

(B) the coordination of state efforts to reduce usage of tobacco and tobacco products.

The Indiana Tobacco Control 2010 Strategic Plan is a State of Indiana plan coordinated by ITPC. ITPC seeks the input and collaboration of many partners, from state agencies to grass-roots community organizations in implementing this plan to reduce Indiana's burden from tobacco. As organizations sign onto strategies and tactics outlined in this plan, this document will be updated to reflect participating groups. Partners will be identified along with the tactics they will be working on to help Indiana achieve its 2010 objectives. Additional organizations are not precluded from addressing tactics that are being conducted by ITPC and other organizations. Partnerships are needed across Indiana to tackle tobacco's burden.

Priority Areas

The 2010 strategic plan includes six priority areas. This section outlines the short term, intermediate, and long term objectives that will be used to track progress toward the achievement of each priority area. Program outputs are drawn from the strategies recommended by the Centers for Disease Control and Prevention (CDC) Best Practices for Tobacco Control and the Task Force on Community Preventive Services on Tobacco as effective to prevent and reduce tobacco use.

Key short-term, intermediate and long-term objectives, as well as target populations are identified under each priority area and will be measured at the state level. Start date to achieve these objectives is January 1, 2006.

1. **DECREASE INDIANA YOUTH SMOKING RATES**

2. **INCREASE PROPORTION OF HOOSIERS NOT EXPOSED TO SECONDHAND SMOKE**

3. **DECREASE INDIANA ADULT SMOKING RATES**

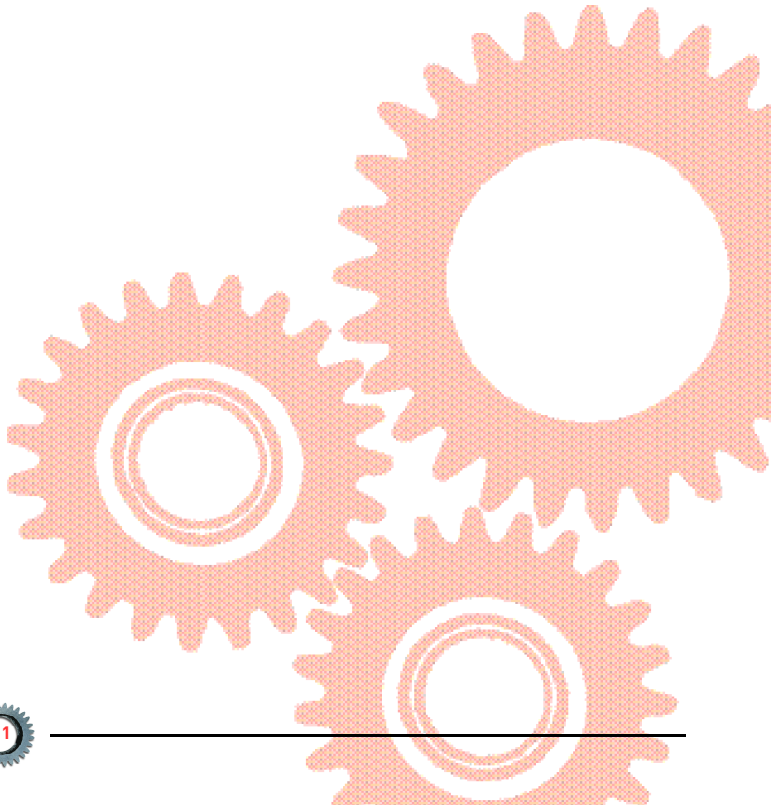
4. **INCREASE ANTI TOBACCO KNOWLEDGE, ATTITUDES AND BELIEFS NECESSARY FOR SMOKING BEHAVIOR CHANGE TO OCCUR**

5. **INCREASE INDIANA'S TOBACCO TAX TO REDUCE ADULT SMOKING AND PREVENT YOUTH SMOKING**

6. **MAINTAIN STATE AND LOCAL INFRASTRUCTURE NECESSARY TO LOWER TOBACCO USE RATES AND THUS MAKE INDIANA COMPETITIVE ON ECONOMIC FRONTS.**

The following tables outline the selected short term, intermediate, and long term outcome indicators measuring achievement of these six priority areas. The data from the years 2000 to 2004 are indicated in BOLD. For some measures, data from 2006 is available to date, and it's also indicated in BOLD. Numbers provided for the years 2006 to 2010 are projected targets for each measure, based on available trend data from 2000-2006. If only one year's data was available, targets for this measure will be set once two years of data is available. Some measures do not have data sources identified. Data and targets for subsequent years will be set when data is available.

These tables will be updated annually and disseminated in the ITPC annual report and evaluation reports from the ITPC evaluation and research coordinating center.



Priority Area 1 – Decrease youth smoking rates

Year	**2000**	**2002**	**2004**	**2006**	2008	2010	Data Source(s)
Long Term Objectives							
Decrease smoking among middle school youth							
	9.8%	**8.6%**	**7.8%**	6-8%	5-7%	5-7%	Youth Tobacco Survey
Decreasing smoking among high school youth							
	31.6%	**23.4%**	**21.3%**	19-21% **21.9%** **(2005)**	18-19%	16-18%	Youth Tobacco Survey Youth Risk Behavior Survey
Intermediate Objectives							
Decrease the noncompliance rate of tobacco sales to youth							
	NA	**20%**	**13%**	**9.8%**	8%	<5%	Tobacco Retailer Inspection Program
Increase Indiana's tobacco tax							
	15.5	**55.5**	**55.5**	**55.5**	150.0	150.0	Orzechowski & Walker, Tax Burden on Tobacco
Increase proportion of youth reporting "not open to smoking"							
Middle school youth	**54.3%**	**56.0%**	**63.5%**	66%	68%	70%	Youth Tobacco Survey
High school youth	**30.0%**	**35.0%**	**41.5%**	44%	47%	50%	Youth Tobacco Survey
Short Term Objectives							
Increase level of confirmed awareness of the countermarketing campaigns							
	NA	**66.4%**	**80.0%**	80%	80%	85%	Youth Media Tracking Survey
Increase the proportion of school districts with a tobacco free campus policy							
	NA	**NA**	**35%**	**54%**	60%	90%	ITPC Policy Tracking
Increase the proportion of youth who think smoking does not make people look cool and fit in							
Middle school youth High School youth	**76.4%** **63.2%**	**73.0%** **68.0%**	**74.5%** **68.9%**	78% 72%	82% 77%	85% 80%	Youth Tobacco Survey Youth Tobacco Survey

Actual; Projected;
NA=data not available; TBD=target to be determined

Priority Area 2 – Increase proportion of Hoosiers not exposed to secondhand smoke

Year	**2000**	**2002**	**2004**	**2006**	2008	2010	Data Source(s)
Long Term Objectives							
Increase the proportion of the population that is protected from secondhand smoke by law							
	3%	**6%**	**6%**	**36%**	50%	65%	ITPC Policy Tracking; U.S. Census data
Intermediate Objectives							
Increased proportion of adults protected from secondhand smoke at the workplace (compliance with policy)							
	60%*	**70.7%**	**72.5%**	77%	85%	90%	Adult Tobacco Survey; *Current Population Survey-Tobacco Use Supplement(2000/2001)
Increase proportion of youth not exposed to secondhand smoke (room/car)							
	TBD	**70%**	**74%**	75%	80%	85%	Youth Tobacco Survey
Short Term Objectives							
Increase level of confirmed awareness of countermarketing campaigns							
	NA	**51.0%**	**78.5%**	80%	80%	85%	Media Tracking Survey
Increase proportion of adults that believe secondhand smoke exposure is a serious health hazard							
	NA	**NA**	**60%**	70%	80%	90%	Adult Tobacco Survey
Increase the level of support for tobacco free policies in public places and work places							
	NA	**74.0%**	**71.5%**	75%	80%	85%	Adult Tobacco Survey
Increase the proportion of households that report a smoke free home							
	NA	**60.1%**	**64.9%**	70%	75%	80%	Adult Tobacco Survey
Increase the proportion of working adults with smoke free worksites							
	NA	**70.7%**	**72.0%**	77%	80%	85%	Adult Tobacco Survey; Behavior Risk Factor Surveillance Survey
Increase the proportion of school districts with a tobacco free campus policy							
	NA	**NA**	**35%**	**54%**	60%	90%	ITPC Policy Tracking

Actual; Projected;
NA=data not available; TBD=target to be determined

Priority Area 3 – Decrease adult smoking rates

Year	**2000**	**2002**	**2004**	**2006**	2008	2010	Data Source(s)
Long Term Objectives							
Decrease smoking among all adults							
	27%	**26.9%**	**24.9%**	24-25% **27.3% (2005)**	23-24%	21-23%	Behavior Risk Factor Surveillance Survey
Decrease smoking among Young adults (age 18-24)							
	37.3%	**37.6%**	**28.2%**	32-34% **39% (2005)**	28-30%	27-28%	Behavior Risk Factor Surveillance Survey
Decrease smoking among Pregnant Women							
	21%	**19%**	**NA 18.5% (2003)**	17-18%	16-17%	15-16%	Birth Certificate Data Indiana Natality Report
Decrease smoking among African Americans							
	24.6%	**27.6%**	**27.4%**	30-32% **36.8% (2005)**	26-28%	24-26%	Behavior Risk Factor Surveillance Survey
Decrease smoking among Latinos							
	22.5%	**24.5%**	**22.8%**	24-26% **33.3% (2005)**	22-25%	20-22%	Behavior Risk Factor Surveillance Survey
Decrease smoking among Medicaid members							
	NA	**NA**	**NA**	**NA**	TBD	TBD	TBD
Decrease smoking among State employees							
	NA	**NA**	**NA**	**NA**	TBD	TBD	TBD
Intermediate Objectives							
Increase Indiana's tobacco tax							
	15.5	**55.5**	**55.5**	**55.5**	150.0	150.0	Orzechowski & Walker, Tax Burden on Tobacco
Increase percent of smokers reporting attempts to quit smoking							
	NA	**48.5%**	**47.6%**	50%	55%	60%	Adult Tobacco Survey
Increase the use of cessation services among smokers							
	NA	**24.3%**	**37.0%**	40%	45%	50%	Adult Tobacco Survey

Actual; Projected;
NA=data not available; TBD=target to be determined

Priority Area 3 – Decrease adult smoking rates (continued)

Year	**2000**	**2002**	**2004**	**2006**	2008	2010	Data Source(s)
Short Term Objectives							
Increase level of confirmed awareness of the countermarketing campaigns							
	NA	**51.0%**	**78.5%**	80%	80%	85%	Adult Media Tracking Survey
Increase the number of calls to the Indiana Tobacco Quitline							
	NA	**NA**	**NA**	**3,500 calls**[2]	TBD	TBD	Smokefree Indiana/ Indiana Tobacco Quit Line
Increase the proportion of smokers that report intentions to quit smoking in the next 30 days							
	NA	**24.6%**	**24.1%**	27%	32%	35%	Adult Tobacco Survey
Increase the awareness of cessation services among smokers							
	NA	**60.0%**	**65.9%**	70%	73%	75%	Adult Tobacco Survey
Increase the proportion of smokers that were advised by the health care professional to quit smoking							
	NA	**67.7%**	**74.9%**	78%	82%	85%	Behavior Risk Factor Surveillance Survey (200?); Adult Tobacco Survey
Increase the proportion of pregnant women smokers advised by the health care professional to quit smoking							
	NA	TBD	TBD	TBD	TBD	TBD	Adult Tobacco Survey

Actual; Projected;
NA=data not available; TBD=target to be determined

2 - Calls from March 22 to June 30, 2006

Priority Area 4 – Increase anti-tobacco knowledge, attitudes, and beliefs necessary for smoking behavior change to occur

Year	**2000**	**2002**	**2004**	**2006**	2008	2010	Data Source(s)
Short Term Objectives-Youth focused							
Increase proportion of youth reporting "not open to smoking"							
Middle school youth High school youth	**54.3%** **30.0%**	**56.0%** **35.0%**	**63.5%** **41.5%**	66% 44%	68% 47%	70% 50%	Youth Tobacco Survey
Increase the proportion of youth who think smoking does not make people look cool and fit in							
Middle school youth High School youth	**76.4%** **63.2%**	**73.0%** **68.0%**	**74.5%** **68.9%**	78% 72%	82% 77%	85% 80%	Youth Tobacco Survey
Short Term Objectives-Adult focused							
Increase level of confirmed awareness of countermarketing campaigns							
	NA	**51.0%**	**78.5%**	80%	80%	85%	Media Tracking Survey
Increase proportion of adults that believe secondhand smoke exposure is a serious health hazard							
	NA	**NA**	**60%**	TBD	TBD	TBD	Adult Tobacco Survey
Increase the level of support for tobacco free policies in public places and work places							
	NA	**74.0%**	**71.5%**	75%	80%	85%	Adult Tobacco Survey
Increase the proportion of smokers that report intentions to quit smoking in the next 30 days							
	NA	**24.6%**	**24.1%**	27%	32%	35%	Adult Tobacco Survey
Increase understanding of dangers of "reduced exposure tobacco products"							
	NA	**NA**	**82%**	TBD	TBD	TBD	Adult Tobacco Survey
Decrease the social acceptability of tobacco use							
	NA	**67%**	**64%**	55%	45%	33%	Media Tracking Survey

Actual; Projected;
NA=data not available; TBD=target to be determined

Priority Area 5 – Increase Indiana's tobacco tax to reduce adult smoking and prevent youth smoking

Year	**2000**	**2002**	**2004**	**2006**	2008	2010	Data Source(s)
Long Term Objectives							
Decrease cigarette consumption (million packs/year)							
	758 M packs	**742 M packs**	**605 M packs**	**620 M packs**	500 M packs	450 M packs	Cigarette tax stamp data; Indiana Department of Revenue
Intermediate Objectives							
Increase Indiana's tobacco tax							
	15.5	**55.5**	**55.5**	**55.5**	150.0	150.0	Orzechowski and Walker, Tax Burden on Tobacco
Average for all states			**91.7**	**95.3**			
Short Term Objectives							
Bill for tobacco tax increase was introduced							
		Yes		**Yes**	Yes		Indiana General Assembly
Bill passed one legislative body							
		Yes			Yes		Indiana General Assembly

Actual; Projected;
NA=data not available; TBD=target to be determined

Priority Area 6 – Maintain state and local infrastructure necessary to lower tobacco use rates and thus make Indiana competitive on economic fronts.

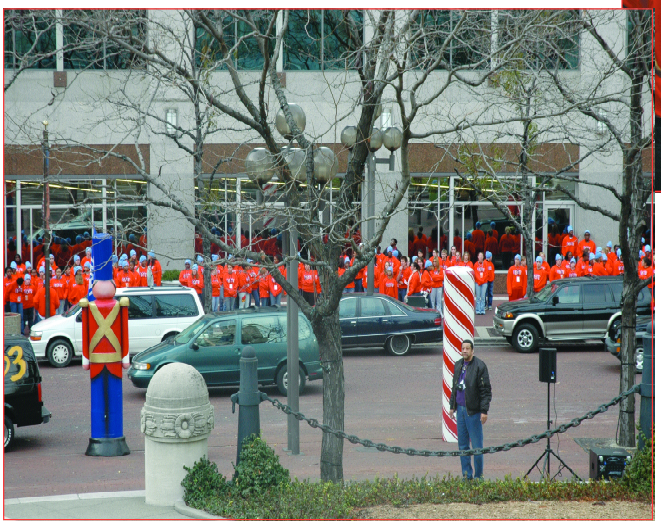
Year	**2000**	**2002**	**2004**	**2006**	2008	2010	Data Source(s)
Objectives							
ITPC annual funding							
	$32.5M	**$32.5M**	**$10.8M**	**$10.8M**	$34.8M	$34.8M	ITPC appropriation
CDC grant (Smokefree Indiana through ISDH)							
	$0.93M[FN1]	**$1.49M**[FN2]	**$1.4M**	**$1.34**[FN3]	TBD	TBD	ISDH/Smokefree Indiana
CDC recommended funding							
	$34.8M	***$34.8M***	***$34.8M***	***$34.8M***	*$34.8M*	*$34.8M*	*Centers for Disease Control and Prevention*
Increase number of organizations supporting the 2010 plan							
	NA	**NA**	**NA**	15	30	30	2010 Strategic Plan
Increase percent of counties with a community-based tobacco control coalition to 100%							
	100%	**100%**	**100%**	**96%**	100%	100%	ITPC
Increase to 100% the proportion of eligible counties with a minority-based tobacco control coalition							
	NA	**70%**	**86%**	**55%**	85%	100%	ITPC
100% of local tobacco control coalitions have an ITPC approved work plan							
	NA	**100%**	**100%**	**100%**	100%	100%	ITPC
Increase program accountability of local coalitions to 95% meeting grant reporting deliverables							
	NA	**NA**	**NA**	**91%**	95%	95%	ITPC
Increase countermarketing spending to $1 per capita spending							
	NA	**$1.14**	**$0.86**	**$0.27**	$1.00	$1.00	Tobacco Control Budget
Level of spending for evaluation and research to 10% of tobacco control budget							
	NA	**10%**	**8%**	**7.4%**	10%	10%	Tobacco Control Budget
Maintain tobacco quitline for Medicaid, uninsured, and pregnant women							
	NA	**NA**	**NA**	**Yes**	**Yes**	**Yes**	ISDH/Smokefree Indiana
Develop and implement an annual training plan							
	Yes	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	Indiana Tobacco Control Partners

Actual; Projected;
NA=data not available; TBD=target to be determined

1 Sept. 1999-May 2000
2 Includes $92,000 supplemental funding for identifying tobacco related disparities
3 Includes $250,000 supplemental funding for Indiana Tobacco Quitline


BAXTER
YMCA
Active Older Adults


Indiana Cigarette
Millions of Stamps
800
750
700
650
600
550
742
739
2002



Tobacco Use Burden on Indiana

Tobacco use is the single most preventable cause of death and disease in the United States. Smoking alone is responsible for 438,000 premature deaths in the United States annually, killing more people than alcohol, AIDS, car accidents, illegal drugs, murders and suicides, combined[1]. Close to 9,700 of these deaths happen to Hoosiers[2]. These include deaths from lung and other cancers, cardiovascular diseases, infant deaths attributed to maternal smoking, and burn deaths. These premature deaths also include deaths from lung cancer and heart disease attributable to exposure to secondhand smoke.

Secondhand smoke

Secondhand smoke is a mixture of sidestream smoke and exhaled smoke in the air. Secondhand smoke has been designated as a known human carcinogen (cancer-causing agent) by the U.S. Environmental Protection Agency (EPA), National Toxicology Program and the International Agency for Research on Cancer (IARC). Secondhand smoke contains over 4,000 compounds, more than 50 carcinogens and other irritants and toxins[3]. Secondhand smoke contains at least 250 chemicals known to be toxic or carcinogenic (cancer-causing), including formaldehyde, benzene, vinyl chloride, arsenic, ammonia, and hydrogen cyanide[4]. The National Institute for Occupational Safety and Health has concluded that secondhand smoke is an occupational carcinogen. Secondhand smoke has been shown to cause heart disease, cancer, respiratory problems and eye and nasal irritation.

Each year in the United States, an estimated 50,000 deaths are attributable to secondhand smoke breathed by nonsmokers, making it the third leading cause of preventable death. Of these deaths, 3,000 are due to lung cancer, 46,000 due to heart disease and approximately 430 infants to sudden infant death syndrome (SIDS) each year[5]. For every eight smokers that die from tobacco use, one nonsmoker dies from exposure to secondhand smoke[6].

In Indiana each year 950-1,690 Hoosiers die from others' smoking, such as exposure to secondhand smoke or smoking during pregnancy[7]. Infants' exposure to secondhand smoke is two to four times more likely to result in low birth weight[8]. Over 900 low birth weight babies in Indiana are born as a result of secondhand smoke[9].

The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Surgeon General's Report

On June 27th, U.S. Surgeon General Richard H. Carmona issued a comprehensive scientific report, which concludes that there is no risk-free level of exposure to secondhand smoke. The report, **The Health Consequences of Involuntary Exposure to Tobacco Smoke**[10], provided the following six conclusions:

1. Many millions of Americans, both children and adults, are still exposed to secondhand smoke in their homes and workplaces despite substantial progress in tobacco control.
2. Secondhand smoke exposure causes disease and premature death in children and adults who do not smoke
3. Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.
4. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.
5. The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.
6. Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.

Exposure to secondhand smoke takes place in the home, public places, worksites and vehicles. The Centers for Disease Control and Prevention's National Report on Human Exposure to Environmental Chemicals estimates that 43 percent of the U.S. population had measurable levels of serum cotinine in their blood, a biomarker of secondhand smoke exposure. This level represents a 70 percent decrease in median cotinine levels for nonsmokers in the U.S. from 1988-91 to 2001-02; however, there is still much work to be done in protecting the public from exposure to secondhand smoke, especially in Indiana[11].

Due to the increase in local smoke free air laws in the 2005-2006, approximately 36 percent of all Hoosiers are now protected from secondhand smoke exposure in public places and worksites. At work, seven out of ten adult indoor workers have a smoke free worksite policy. However, not all workers are protected equally. Less than half of the nation's food service workers reported having a smoke free place of employment, compared to over 75 percent of all white-collar workers, including 90 percent of teachers[12].

Unfortunately, the same laws that provide for smoke free office workplaces and public places often neglect bars and restaurants, leading to a discrepancy in worker exposure to secondhand smoke. Just 43 percent of the country's 6.6 million food preparation and service employees and just 52 percent of all blue-collar workers are covered by smoke-free workplace policies, while more than 75 percent of white collar workers are protected. Fewer than 13 percent of bartenders and 28 percent of waiters/waitresses have the benefit of smoke free workplace policies. In 2002, food service workers in U.S. accounted for the fourth highest number of employees in the workforce and is one of the fastest growing segments of the workforce according to the Bureau of Labor Statistics. One in five food service workers are teenagers, 56 percent are female; 12 percent are African-American and nearly 20 percent are Hispanic.

Indiana workers fair worse, as less than half of service (49.5%) and blue collar (45.3%) workers have an indoor smoke free worksite, while 70 percent of white-collar workers enjoy a smoke free worksite[13]. These policies show that Indiana is lagging behind.

Almost 60 percent of U.S. children aged 3-11 years, almost 22 million children, are exposed to secondhand smoke, including an estimated 420,000 Hoosier children[14]. In Indiana, one in four youth (26%), grades 6-12, are exposed to secondhand smoke daily. Youth who are non-smokers were less likely than current smokers to be exposed to others' smoking[15].

Sixty-one percent of youth in grades 6-8 reported being in the same room with someone who is smoking at least one day per week, while nearly 40 percent are exposed three or more days each week. Among high school youth, 43 percent were exposed to secondhand smoke more than 3 days in the past week, a decline from 51 percent in 2000. Exposure to smoke in a car of at least one day in the past week also declined from 60 percent in 2000 to 48 percent in 2004. These findings suggest even greater emphasis on encouraging smoke free homes and cars as well as encouraging youth to refuse being in smoke filled environments.

Health Effects from Secondhand Smoke Exposure

Secondhand smoke exposure causes disease and premature death in children and adults who do not smoke[16]. Sidestream smoke has been found to be four times more harmful that mainstream smoke[17]. The effects of even brief exposure (minutes to hours) to secondhand smoke are often nearly as large as chronic active smoking[18].

Short exposures to secondhand smoke can cause blood platelets to become stickier, damage the lining of blood vessels, decreased coronary flow velocity reserves, and reduced heart rate variability, potentially increasing the risk of a heart attack. Secondhand smoke contains many chemicals

that can quickly irritate and damage the lining of the airways. Even brief exposure can result in upper airway changes in healthy persons and can lead to more frequent and more asthma attacks in children who already have asthma.

Health Effects on Children

Children who are exposed to secondhand smoke are inhaling many of the same cancer-causing substances and poisons as smokers. Children are especially affected by secondhand smoke because their bodies are still developing and can hinder the growth and function of their lungs.

Millions of doctor visits and thousands of hospitalizations occur due to children's exposure to secondhand smoke. Hundreds of thousands of lung and bronchial infections are caused by secondhand smoke each year[19].

Major Health Effects of Secondhand Smoke Exposure in Children

Sudden Infant Death Syndrome (SIDS)	Secondhand smoke causes irritation of the airways; maternal smoking is a risk factor for SIDS and lower birth weight
Acute and Chronic Respiratory Illnesses	Secondhand smoke particles get into the airways and alveoli; can increase severity with irritation of the lungs; greatest impact occurs during first year of life
Asthma	Smoking during pregnancy may affect lung growth; secondhand smoke increases risk of lower respiratory infection
Middle Ear Disease	Secondhand smoke exposure strongly linked with ear infections

Both babies whose mothers smoke while pregnant and babies who are exposed to secondhand smoke after birth are more likely to die from sudden infant death syndrome (SIDS) than babies who are not exposed to cigarette smoke. Babies whose mothers smoke while pregnant or who are exposed to second-hand smoke after birth have weaker lungs than unexposed babies, which increases the risk for many health problems. The National Cancer Institute estimated that exposure to secondhand smoke resulted in more than 10,000 annual cases of low birthweight and more than 2,000 cases of sudden infant death syndrome[20]. Secondhand smoke is as damaging to a fetus as if the mother were inhaling the smoke directly from a cigarette[21].

Children and infants exposed to secondhand smoke in the home have dramatically higher levels of respiratory symptoms and respiratory tract infections[22]. Children of parents who smoke also have an increased number of respiratory infections and symptoms and slower lung development[23].

Asthma is the most common chronic illness among children. Secondhand smoke exposure can cause children who already have asthma to experience more frequent and severe attacks. There is a strong association between exposure to secondhand smoke, especially from parents, and childhood asthma[24]. Compared to children of never-smokers, children whose mothers smoked throughout pregnancy have higher risk of asthma during the first five years of life[25]. The EPA reported that secondhand smoke annually causes 8,000 – 26,000 new cases of asthma, 200,000 pediatric asthma attacks, and 150,000- 300,000 cases annually of lower respiratory tract infections in children up to 18 months old[26]. Asthma cases attributed to secondhand smoke cost the U.S. more the $236 million[27]. In Indiana, over 11,000 cases annually are attributed to secondhand smoke exposure costing nearly $9 million[27]. Secondhand smoke exposure is also associated with increased respiratory-related school absences[29].

Research indicates that exposure to parental smoking is associated with a greater risk of ear infections. More than 24 million office visits to physicians occur each year for acute ear infections in children under age 15[30]. Approximately 4,500 ear infections cases attributable to secondhand smoke occur in Indiana each year, costing Hoosiers $2.2 million[31].

Secondhand smoke exposure impairs a child's ability to learn. It is neurotoxic even at extremely low levels. More than 21.9 million children are estimated to be at risk of reading deficits because of secondhand smoke. Higher levels of exposure to secondhand smoke are also associated with greater deficits in math and visuospatial reasoning[32].

Coronary Heart Disease

Breathing secondhand smoke for even a short time can have immediate adverse effects on the cardiovascular system and interferes with the normal functioning of the heart, blood, and vascular systems in ways that increase the risk of a heart attack. The International Agency for Research on Cancer (IARC) that "epidemiological studies have demonstrated that exposure to secondhand tobacco smoke is causally associated with coronary heart disease". A study released in 2003 monitored the hospital admissions of in Helena, Montana for heart attacks during a sixth month period[35]. Compared those numbers to the same time period in the previous four years, and with data for the surrounding area not affected by a smoke free law, researchers found a 40% drop in admissions for heart attacks from people living or working in Helena (where a smoke free ordinance was in effect) and no change for people living further away. A subsequent study in Pueblo, Colorado illustrated a similar effect after the implementation of a smoke free air law there. These studies and other findings supporting the link between secondhand smoke exposure and heart disease prompted the CDC to issue a warning to people at risk for heart disease to avoid all buildings and gathering places that allow indoor smoking. This warning stressed that as little as 30 minutes of exposure to secondhand smoke can have a negative health effect[36].

The effects of secondhand smoke exposure are nearly as large as those experienced from active smoking[37]. The cardiovascular mechanisms altered by exposure to secondhand smoke that increase the risk of heart disease are complex. These include atherosclerosis, endothelial dysfunction, platelet activation, increase insulin resistance, among others.

The excess risk of coronary heart disease (CHD) associated with passive smoking is 50-60%, twice what was previously thought by researchers, and the risks of CHD for passive smoking are virtually indistinguishable from active smoking. A study published in the July 2004 edition of the British Medical Journal found higher risks of CHD because, rather than using marriage to a smoker or working in a smoky environment as their measure of exposure, the study's authors used plasma cotinine (metabolized nicotine), a direct biochemical measure of total secondhand smoke exposure. By doing so, they captured secondhand smoke's entire exposure effect[38].

There is a link between secondhand smoke to an increased risk of stroke. Regular exposure to secondhand smoke, such as in restaurants, heightens one's chance of stroke by 50 percent.[38]

Cancer

The U.S. Public Health Service's National Toxicology Program in its 10th Report on Carcinogens, states secondhand smoke is a known human carcinogen, which indicates that there is a cause and effect relationship between exposure and human cancer incidence[39]. Nonsmokers who are exposed to secondhand smoke at home or at work increase their risk of developing lung cancer by 20 - 30 percent[40].

Studies examining the relationship between exposure to secondhand smoke and nasal sinus cancers show strong associations in nonsmoking adults[41]. New findings also indicate that long-term exposure to secondhand smoke increases the risk of developing breast cancer in younger, primarily premenopausal, women[42].

Economic Impact of Tobacco Use

The economic burden of secondhand smoke exposure in the U.S. is estimated at $10 billion annually, $5 billion from direct medical costs and $5 billion from indirect costs.

In Marion County, Indiana alone at least $16.7 million were spent for the hospitalization and health care of Marion County residents with secondhand smoke exposure-caused diseases: $6.2 million for adults and $10.5 million for children. Additionally, at least $39.5 million were lost due to premature death that can be attributed to secondhand smoke exposure: $19.2 million for adults and $20.3 million for children. Combined, the costs of health care and the costs of premature loss of life for diseases attributed to secondhand smoke in Marion County were estimated to be at least $56.2 million in 2000[43].

Tobacco's Burden on Business

Another finding of the study on Marion County, indicates that employees who smoked cost Marion County businesses an additional $260.1 million dollars in increased health insurance premiums, lost productivity, fires, absenteeism, and extra housekeeping.

Businesses are constantly looking for ways to cut costs and increase productivity. The health of employees is the major factor in a business's bottom line. Tobacco use among Hoosiers is a burden for Indiana and for business. When employees smoke, they are not the only ones who pay. Increased medical costs, higher insurance rates, added maintenance expenses, lower productivity, and higher rates of absenteeism from smoking costs American businesses billions every year.

Benefits of a smoke free workplace:

- Improvement in employee and visitor health
- Lower absenteeism and increased productivity
- Employee support for non-smoking policies
- Reduced liability of claims
- Lower maintenance costs
- Lower insurance premiums

Employees who smoke get sick more often and thus are more expensive to employers than nonsmoking employees. The U.S. Office of Technology and Assessment reported that current smokers averaged almost three times as much sick leave as non-smokers, and significantly more sick leave than former smokers. Employees that smoke visit health-care professionals up to six times more often than non-smokers[44]. They are admitted to the hospital almost twice as often as non-smokers; average 1.4 additional days in the hospital per admission over non-smokers; and incur more workplace injuries than non-smokers[45]. A study of 300 booking clerks at a large U.S. airline found that smokers are absent from work for sickness as many as 6.16 days per year on average, compared with 3.86 days for those employees who never smoke[46]. Studies on workplaces have also shown workers' compensation costs for a smoker averaged $2,189 compared to only $176 for a nonsmoker[47]. In addition, costs for employee absences include temporary replacements and lowered productivity and morale among employees who are on the job dealing with the absences. Smoking can cost employers an extra $45 per year for accidental injury and related workers' compensation costs[48]. Finally, higher carbon monoxide levels, eye irritation, and lower attentiveness of smokers can cause an increase in inefficiency and errors.

Together, medical costs and the cost of lost productivity are a heavy burden to employers. Economic costs of smoking are estimated to be about $3,391 per smoker per year: $1,760 in lost productivity and $1,623 in excess medical expenditures[49].

A smoke free workplace contributes positively to the bottom line. Smoke free laws add value to establishments. Restaurants in smoke free cities have a higher market value at resale (an average of 16 percent higher) than comparable restaurants located in smoke-filled cities[50].

Making workplaces smoke free will lower business costs and produce a healthier work-force. Eliminating tobacco use in the workplace projects a positive image to the public and demonstrates pride in the business and the products and services the company delivers.

Fires are another concern. Cigarette-caused fires are the #1 cause of fire death in U.S. Direct property loss due to fires in the US was an estimated $10.6 billion in 2001[51]. Health and fire insurance premiums can be 25 percent to 35 percent lower for smoke free businesses, and morbidity and fire statistics suggest that premium discounts should be as high as 70 percent[52].

Active smoking in the U.S. has a significant economic impact. Tobacco costs the United States an estimated $75.5 billion annually in medical expenses and $92 billion in lost productivity[53]. Smoking-attributable direct medical expenditures totals $1.9 billion in Indiana each year. These expenditures include annual individual expenditures for four types of medical services, including ambulatory care, hospital care, prescription drugs, and other care (including home health care, nonprescription drugs, and other non-durable medical products). This calculates to $522 per Hoosier household in direct medical expenses related to smoking regardless of whether they smoke or not.

Indiana spends $7.10 in smoking related costs to the State for every pack of cigarettes sold[54]. A report prepared for the Indiana Hospital & Health Association by Pricewaterhouse Coopers states that Indiana's increase in health insurance premiums can be attributed to volume, increased labor costs, and other costs to the hospital. Nearly half of this increase is due to volume, which is driven by an aging population and unhealthy lifestyles, such as smoking[55]. These increases in health insurance premiums are not directly associated with increases in total spending on services, but are a result of unhealthy behaviors.

Smoking-attributable direct medical expenditures are rising, largely because of medical care inflation and inflation-adjusted, real increases in health care expenditures in the United States. As all states struggle to curb Medicaid costs, it is important to note that about 16 percent or $448 million of all Indiana Medicaid expenditures are related to smoking. Medicaid costs related to smoking increased by 32.9 percent from 1993-1998 in Indiana[56].

If Indiana continues its current spending for a tobacco prevention program over the next 25 years, it would spend less than it spends, in just one year, caring for dying and sick smokers. Indiana's comprehensive tobacco control program can save the state millions of taxpayer dollars. If Indiana reduced smoking by 25 percent, it would save Indiana taxpayers over $20 million per year in smoking-related Medicaid costs[56].

Lifetime Healthcare Savings	
Adult Medicaid Smoker that Quits	**$1,340**
Youth Medicaid enrollee that quits or does not start smoking	**$1,950**

There are an estimated 275,000 smokers enrolled in Indiana's Medicaid program. At $1,950 each that equates to a total cost of $536 million[57].

In August 2005, Patrick M. Barkey, Ph.D. from the Bureau of Business Research at Ball State University completed an analysis of the impact of tobacco from a labor and manufacturing and overall economic perspective, titled "The Economic Impact of Tobacco Use in Indiana". This report indicated that Indiana's smoking behavior has wide ranging impacts on the Indiana economy, both in the private and public sector.

Because there is tobacco use 1) we have a tobacco industry, which employs people in farming, processing, distribution, advertising, and taxation and regulation; 2) we have demands on the health care system – which produce employment --to treat tobacco-attributable disease, borne by smokers and non-smokers (through secondhand smoke) alike, which consumer resources and increase taxes and labor costs; 3) businesses pay health care premiums, fire insurance premiums, and losses stemming from higher absenteeism rates and lower productivity that reflect the fact that many of their workers are smokers or use tobacco.

Since Indiana is a relatively high smoking state, these undesirable impacts of tobacco use put businesses here at a competitive disadvantage. In order to more fully understand the manner in which the existence of tobacco affects the

performance of the state economy, we have carefully constructed an economic projection that answers a very simple question: what would the Indiana economy look like if tobacco did not exist?

The overall finding is that tobacco use in Indiana exacts a painful, significant cost on the overall economy. Specifically, we find that in an Indiana economy where tobacco was not used or produced:

- More than 175,000 more jobs would exist;
- Personal income would be $28.7 billion higher;
- After-tax income would be 7 percent higher;
- Population would be more than half a million people higher;
- Almost half of that population gain, or about 220,000 people, would be migrants from other states;
- More than $100 billion in cumulative new investment would take place;
- Per capita income would be about $108 higher.

These changes occur as the different mechanisms that cause smoking behavior to reduce the size of the economic pie are "undone." Employer non-wage labor costs fall as tobacco induced heath care expenditures are eliminated. Workers who would otherwise retire early go on to enjoy normal length working lives. Those who would die – in the status quo economy --from tobacco-related ailments instead live average length lives, consuming goods and services in a state that is tobacco-free. As a result of these changes, investment, jobs, and migration patterns change significantly to produce a significantly larger, wealthier economy.

The results of this study support a growing body of evidence that suggests that tobacco is more than simply a killer of people. It is also a killer of jobs and wealth. As such, public policies that seek to limit its use have strong justification. The full study can be found at **http://www.in.gov/itpc/files/research_286.pdf.**

Tobacco Cessation is a Bargain Among Preventive Health Measures

Paying for tobacco use cessation treatments is the single most cost-effective health insurance benefit for adults[58]. There are few preventive health interventions that are more cost-effective than tobacco cessation. Tobacco cessation is the only service with a proven return on investment that is also a national standard of care according to organizations such as the Centers for Disease Control & Prevention (CDC), National Institute of Health (NIH), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Centers for Medicare and Medicaid Services (CMS), and National Business Group on Health (NBGH).

Studies suggest the benefits of cessation outweigh the costs and, in fact, offer a net gain over time. It costs between 10 and 40 cents per member per month to provide a comprehensive tobacco cessation benefit (costs vary based on utilization and dependent coverage)[59]. In contrast, the annual cost of tobacco use is about $3,391 per smoker nationally or about $7.10 in smoking related costs for each pack of cigarettes sold in Indiana[60].

Researchers at the University of Michigan simulated the financial results of a workplace cessation program. The results suggested that, by the third year, the savings to the company matched the total costs of the cessation program. By the fifth year, the financial benefits were almost twice the costs[61]. Studies indicate that a smoking cessation program for pregnant women can save as much as $6 for each $1 invested[62]. Neonatal healthcare costs related to smoking are equivalent to $704 for each maternal smoker.

Cost Benefit Analysis of Cessation Programs Offered by Employers:

		Estimated # of employees who smoke	Total Estimated Cost
Estimated cost of smokers to employer	$1,300	_____	$_____
Estimated cost of cessation program to employer	$45	_____	$_____
Total Potential Savings			$_____

Indiana State Government is taking a leadership role in reducing health care costs from tobacco use. Governor Mitch Daniels' leadership with INShape Indiana has given tobacco cessation increased awareness among State employees, businesses and all Hoosiers. In November 2005, Governor Daniels announced that the smoking policy will be revised to ban smoking on the grounds of the Government Center Complex, including common areas, parking lots and garages to state employees. Governor Daniels' action underscores the growing momentum across Indiana for smoke-free policies that protect all workers, customers and visitors from the proven dangers of secondhand smoke.

Increased opportunities for smoking cessation have been provided for employees. This expands the partnership that ITPC and the Indiana State Personnel Department (ISPD) formed in 2003, to promote cessation services to all State employees. ITPC shares information through a variety of communication tools aimed at State workers, such as the State Personnel newsletter, state agency websites, regular contact with all agency human resource directors and ISPD events throughout the year to promote new and existing resources to help people quit smoking. The State is Indiana's second largest employer with 35,000 employees and over 80,000 lives covered under the State's health plans. By reducing tobacco use and improving the overall health of state workers, the plan will also work to reduce healthcare costs. With local coalitions working in Indiana's counties, ITPC has the resources in place to work with any Indiana business looking to encourage tobacco cessation.

Governor Daniels took another step in supporting tobacco control with the proposed tobacco tax increase in January 2006. Health organizations statewide rallied support for the Governor Daniels' proposed minimum 25-cent increase in cigarette sales tax—a tax to prevent youth initiation, reduce adult tobacco use and save Hoosier lives and untold dollars in healthcare. More on the benefits of increasing the tobacco tax on page 49.

Adult Smoking

In 2005, an estimated 1.2 million adults in Indiana smoke cigarettes. This makes up 27.3% of the State's adult population. Indiana is consistently in the list of states with the highest smoking rates and consistently higher than the United States, where the adult smoking rate is 20.6%. Indiana measures its adult smoking prevalence using the Indiana Behavior Risk Factor Surveillance Survey (BRFSS) which data is collected annually and can be consistently compared with other states. Indiana's adult smoking rates for 2004 and 2005 do not vary statistically. However, the overall adult rate and the rates of sub-populations have increased, despite the decline experienced between 2002 and 2004. Chart 1 illustrates Indiana's smoking rates from 1995 to 2005.

This increase is also demonstrated by the increase in the consumption of tobacco products, measured through cigarette stamps sales. Cigarette consumption has increased 3 percent in SFY 2006 from SFY 2005. The impact of the tax on cigarette consumption has slowed since SFY 2003, as Indiana's cigarette tax is lower than the current average cigarette tax for all states is 95.3 cents. More details on the cigarette consumption can be found on pages 48-49.

Chart 1: Indiana Adult Smoking Prevalence, 1995-2005

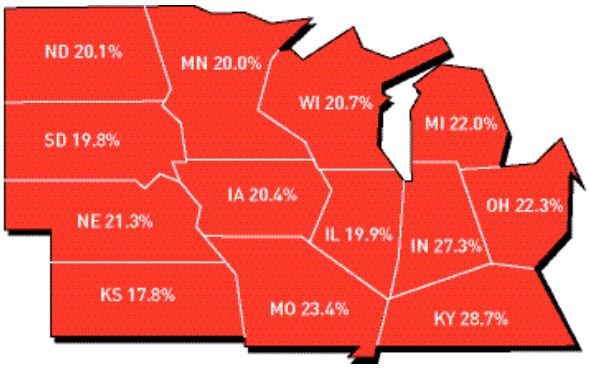
Indiana's adult smoking has returned to levels seen in 1995, after a reversed improvement from 2002-2004.

Table 1: Highest 10 States by Adult Smoking Prevalence, 2005

Rank	State	Smoking Rate	Confidence Intervals
1	Kentucky	28.7	(27.0-30.4)
2	Indiana	27.3	(25.9-28.7)
3	Tennessee	26.7	(24.6-28.8)
4	West Virginia	26.7	(24.9-28.5)
5	Oklahoma	25.1	(23.8-26.4)
6	Alaska	24.9	(22.4-27.4)
7	Alabama	24.8	(22.7-26.9)
8	Mississippi	23.6	(21.9-25.3)
9	Pennsylvania	23.6	(22.4-24.8)
10	Arkansas	23.5	(22.0-25.0)

In 2005, Indiana's smoking rate was 27%. The states with the highest adult smoking rates are listed here. States' smoking ranges from 11.5% in Utah to 28.7% in Kentucky.

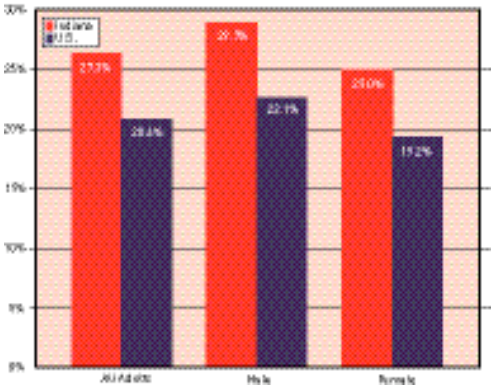
Figure 1: Surrounding States Adult Smoking Prevalence, 2005



With the exception of Kentucky, Indiana has higher adult smoking rates than states in the Midwest region.

One in four Hoosier adults smoke, and some differences are seen in comparing smoking by gender, race/ethnicity and age. Adult smoking rates for men (29.7%) remains significantly higher than those for women (25.0%). Hoosier smoking rates by gender are 23-25 percent h i g her than the all states median as illustrated in *Chart 2: Adult Smoking Prevalence, Indiana vs. U.S.*

Chart 2: Adult Smoking Prevalence, Indiana vs. U.S., 2005



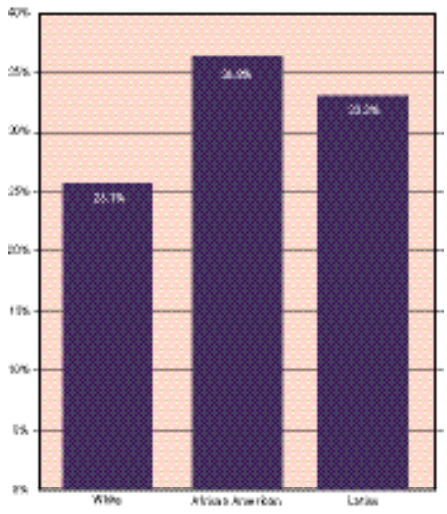
Smoking by Hoosier men and women is higher than U.S. men and women.

Smoking rates in Indiana are varied among race/ethnic groups, as illustrated in *Chart 3: Indiana Adult Smoking Prevalence, Race/Ethnicity, 2005*. The smoking rate for Hispanics is 33.3 percent and the African American adult smoking rate is at 36.8 percent, which is statistically higher than Whites at 26.1 percent. Despite the increase in the 2005 rates from 2004, none of the increases are statistically significant.

Illustrated in *Chart 4: Indiana Adult Smoking Prevalence, Age, 2005*, nearly 40 percent of adults ages 18-24 report current smoking, and more than 30 percent of adults ages 25-44 are current smokers. Smoking declines with ages 45 and older. Smoking among younger adults ages 18-24 increased significantly from 2004 to 2005, as illustrated in *Chart 5: Smoking among youth adults, 2001-2005*. Rates among 18-24 years olds are statistically higher than the age 45 and older age groups. The 55-64 year old age group is statistically lower than the 25-34 year old group. The 65 and older age group is statistically lower than all other age groups.

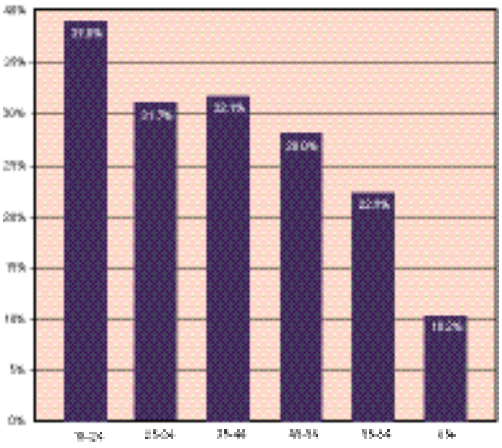
Smoking by Hoosier adults also varies by level of education. Nearly half of adults with less than a high school education currently smoke, which is statistically higher than all other education levels. Rates among adults with less than a high school education have remained high from 2001 to 2005, but have steadily increased since 2003. Smoking rates among men with less than a high school education are nearly 60 percent, and are statistically higher than that of women at 38 percent. As shown in C*hart 6: Indiana Adult Smoking, Education Level, 2005,* as level of education increases, smoking rates among groups decrease.

Chart 3: Indiana Adult Smoking Prevalence, Race/Ethnicity, 2005



The smoking rate for African American adults is significantly higher than Whites.

Chart 4: Indiana Adult Smoking Prevalence, Age, 2005

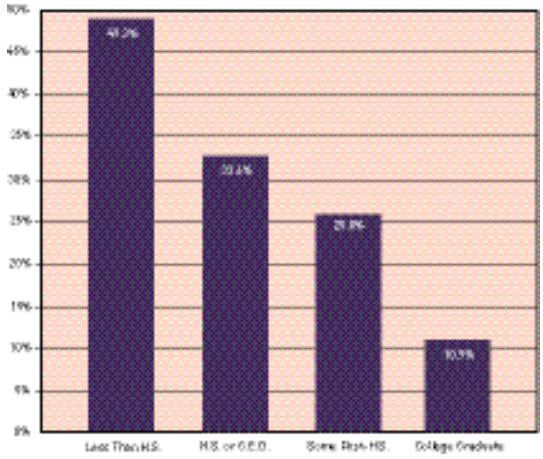


The highest smoking rates are found in the 18-24 age group with smoking rates declining as age increases.

Chart 5: Smoking Among Adults ages 18-24, 2001-2005

Smoking among young adults increased significantly between 2004 to 2005.

Chart 6: Indiana Adult Smoking, Education Level, 2005



Among those adults without a high school diploma, 49% smoke. Smoking rates decline as education increases; with 11% of college graduates as current smokers.

Tobacco's Impact on Minority Populations

African Americans

Each year, approximately 45,000 African Americans die from a preventable smoking-related disease[63]. If current trends continue, an estimated 1.6 million African Americans who are now under the age of 18 years will become regular smokers. About 500,000 of those smokers will die of a smoking-related disease[64]. The smoking rate for Hoosier African Americans (36.8%) is higher than the U.S. rate for African Americans of 20.7 percent[65]. Indiana's smoking rate for African Americans is statistically higher than the smoking rate of Whites.

Other racial/ethnic differences show that approximately three of every four African American smokers prefer menthol cigarettes. Menthol may facilitate absorption of harmful cigarette smoke constituents[66]. Seventy percent of African American smokers in Indiana smoke menthol cigarettes[67]. Research also shows that youth and African Americans like flavor cigarettes. In Indiana, 42 percent of middle school and 36 percent of high school smokers smoke menthols. Of African American youth smokers in Indiana, 42 percent of middle school, and 63 percent of high school smokers usually smoke menthol cigarettes[68].

In 2004, Brown & Williamson Tobacco Company (B&W) promoted their Kool cigarettes and introduced a series of flavored cigarettes in special packs, marketed under the name "Smooth Fusions". The flavors include "Midnight Berry", "Caribbean Chill", "Mintrigue", and "Mocha Taboo". This use of these flavors is further evidence the company is targeting youth, especially black youth. R.J. Reynolds Tobacco Company, through its Camel brand has promoted similar flavored cigarettes.

Kool is a key brand since menthol cigarettes have historically been popular among African Americans. The promotion used a hip-hop theme to promote Kool cigarettes, included special packs called Kool Mixx packs. These packs featured

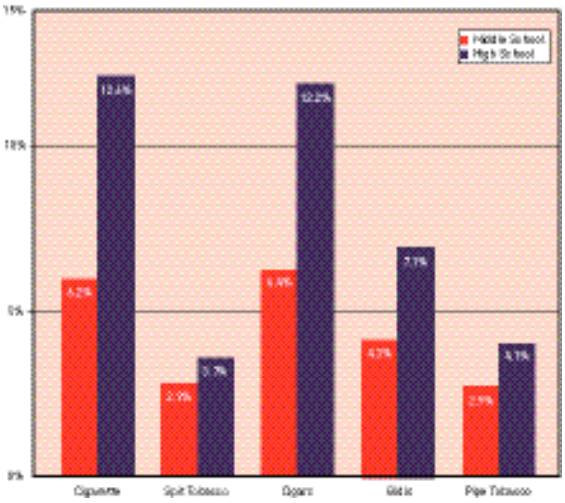
images of juvenile-oriented disc jockeys, hip-hop artists and dancers that displayed a "mural" as the two packs were placed next to each other. These special packs sold for the same price as other Kool products. Thirty states, including Indiana, signed onto a letter from New York's Attorney General outlining intentions to file a lawsuit because of these marketing practices and the potential violation of the MSA. The promotion was soon scaled back.

The tobacco industry attempts to maintain a positive image and public support among African Americans by supporting cultural events and making contributions to minority higher education institutions, elected officials, civic and community organizations, and scholarship programs. A one-year study found that three major African American publications — Ebony, Jet, and Essence — received proportionately higher profits from cigarette advertisements than did other magazines[69].

African American Youth

Approximately 6 percent of African American middle school students report current cigarette use. In *Chart 7: Current tobacco use by Indiana African American Youth, Middle and High School, 2004,* we see that cigars (6.4%) and cigarettes (6.2%) are used most commonly used forms of tobacco followed by bidis (4.3%). Use of these different forms of tobacco is similar among all middle school youth in Indiana.

Chart 7: Current Tobacco Use by Indiana African American Youth, Middle and High School Students, 2004



Cigarettes and cigars are the preferred form of tobacco use among African American youth. The proportion of youth using all tobacco products increases with school grade.

As African American youth age into high school, cigarette and cigar use increase with cigarette use (12.6%) and cigar use (12.2%). There is also an increase in bidis use among high school students (7.1%). Significantly fewer African American high school youth smoke compared to the State's overall rate (21%). In comparing African Americans to other race/ethnic groups, a smaller proportion of African American high school youth use spit tobacco compared to Whites. Cigar use is similar in all groups while bidis are used among African American and Latino high school youth more than White high school youth.

Health Effects of Tobacco for African Americans

African Americans have a higher lung cancer incidence and mortality rates compared to Whites. AfricanAmerican men in Indiana have a higher mortality rate of lung and bronchus cancer (117.7 per 100,000) than do White men (92.2 per 100,000). African American women (52.5 per 100,000) also have higher rates of death due to lung cancer than do White women (45.1 per 100,000)[70]. African American men have the highest cancer burden in the U.S. and this excessive cancer burden is linked to smoking. Cancer death rates among African American males would decline by two-thirds if they did not smoke. Tobacco smoke causes 63 percent of cancer deaths among black men in the U.S.[71].

Smoking significantly elevates the risk of stroke. Stroke is associated with cerebrovascular disease, a major cause of death in the United States. Cerebrovascular disease is twice as high among African American men (53.1 per 100,000) as among White men (26.3 per 100,000) and twice as high among African American women (40.6 per 100,000) as among White women (22.6 per 100,000)[72].

Latinos

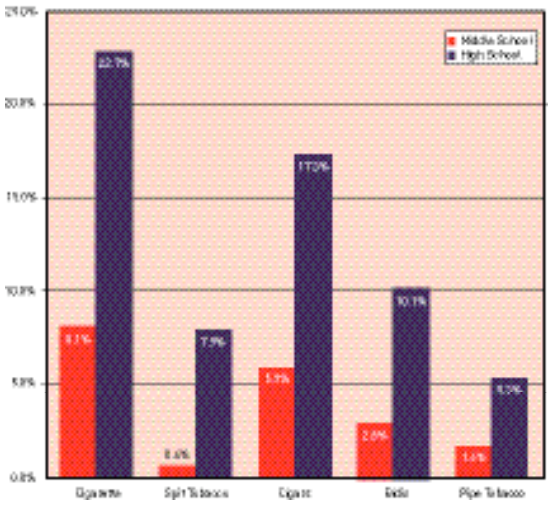
The smoking rate for Latinos in Indiana is higher than all-states median for Latinos (33.3% vs. 19.5%). The smoking rate for Latinos in Indiana does not differ statistically from smoking rate for other race/ethnic groups in Indiana.

Tobacco products are advertised and promoted disproportionately to racial/ethnic minority communities. These include target promotions were marketed to the Hispanic American community to increase its credibility in the community. Tobacco companies have contributed to programs that enhance the primary and secondary education of children, universities and colleges, and have supported scholarship programs targeting Hispanics. Tobacco companies have also placed advertising in many Hispanic publications and contributeto cultural Hispanic events[75].

Latino Youth

Approximately 8 percent of Latino middle school students currently smoke cigarettes, a similar rate for cigars (5.9%). As Latino middle school youth progress into high school, the proportion using all forms of tobacco increase by nearly three times. Approximately 23 percent of Latino high school youth currently smoke cigarettes, while the second most used form of tobacco is cigar use with 17 percent of Latino high school students using these products. This is followed by bidis (10.1 percent) and spit tobacco (7.9 percent). The proportion of Latino high school students using bidis is significantly higher than the proportion of White high school youth using bidis.

Chart 8: Current tobacco use by Indiana Latino Youth, Middle and High School, 2004



Cigarettes and cigars are the preferred form of tobacco among Latino middle and high school youth. High school Latinos also have a high proportion of bidis use compared to Whites.

Health Effects of Tobacco for Latinos

As with the U.S. overall, cancer, heart disease and stroke are the leading causes of death among Latinos. Of cancers, lung cancer is the leading cause of cancer deaths among Latinos[76]. Lung cancer deaths are about three times higher for Latino men (23.1 per 100,000) than for Latino women (7.7 per 100,000)[77].

Coronary heart disease is the leading cause of death for Hispanics living in the United States. Death rates for coronary heart disease were 82 per 100,000 for Mexican American men and 44.2 per 100,000 for Mexican American women, 118.6 per 100,000 for Puerto Rican men and 67.3 per 100,000 for Puerto Rican women, and 95.2 per 100,000 for Cuban men and 42.4 per 100,000 for Cuban women[78].

Pregnant Women

Smoking can impact the lives of even the youngest Hoosiers. It is reported that 18.5 percent of women in Indiana smoked during pregnancy in 2003, a slight decline from 21 percent in 1999[79]. Smoking during pregnancy is associated with poor health outcomes, such as low birth weight, premature birth, growth retardation, and Sudden Infant Death Syndrome (SIDS).

- Twenty to thirty percent of the cases of low birth weight babies can be attributable to smoking[80].
- Women who smoke during pregnancy had more than twice the risk of delivering a low birth weight baby[81].
- Babies with mothers who smoked during pregnancy have twice the risk of SIDS and infants of nonsmoking mothers[82].
- Women who smoke have a higher incidence of ectopic pregnancy.
- Pregnant smokers also have a 30-50% higher risk for miscarriage than nonsmokers.

Pregnant smokers ready to quit should know that it's never too late to quit smoking during your pregnancy. Many pregnant women are tempted to cut down the number of cigarettes they smoke instead of quitting. Cutting down to less than 5 cigarettes a day can reduce risk, but quitting is the best thing pregnant women can do for themselves and their baby. The benefits of quitting smoking can be seen immediately. After just one day of not smoking, the baby will get more oxygen. While women experience withdrawal symptoms these are often signs that the body is healing. They are normal, temporary, and will lessen in a couple of weeks. Quitting will give more energy and helps make breathing easier.

The rate of Indiana mothers who reported smoking during pregnancy is higher than the national average. Even more alarming are rates in Indiana counties that exceed state and national rates. Sixty-four (64) of Indiana's 92 counties have a smoking during pregnancy rate higher than the Indiana average. All but five Indiana counties have smoking during pregnancy rates higher than the United States average. The county rates for women smoking during pregnancy range from 35.5 percent to 5.4 percent.

Table 2: Percent of mothers who reported smoking during pregnancy, Indiana Counties, 2003

County	Total Births	% Smoked	
INDIANA	86,382	18.5	
Adams	641	10.3	S
Allen	5,211	15.1	S
Bartholomew	1,004	19	
Benton	118	16.1	
Blackford	163	28.8	
Boone	699	13.4	
Brown	157	17.8	
Carroll	237	16.5	
Cass	548	25	S
Clark	1,315	23.4	S
Clay	358	25.7	S
Clinton	510	19.4	
Crawford	135	31.9	S
Daviess	502	18.5	
Dearborn	629	24.2	S
Decatur	387	25.3	
DeKalb	566	22.8	
Delaware	1,339	21	
Dubois	501	11	S
Elkhart	3,194	16.1	S
Fayette	332	28.9	S
Floyd	826	22.2	
Fountain	217	23	
Franklin	264	22	
Fulton	263	27	S
Gibson	430	23.5	
Grant	799	24.3	S
Greene	420	21.9	
Hamilton	3,637	5.4	S
Hancock	844	16.6	
Harrison	438	24.2	
Hendricks	1,505	10.6	S
Henry	559	23.8	
Howard	1,217	24.2	S
Huntington	461	26.7	S
Jackson	591	23.5	
Jasper	431	21.1	
Jay	332	23.8	
Jefferson	365	31	S
Jennings	359	28.4	S
Johnson	1,705	15.2	S
Knox	474	30.8	S
Kosciusko	1,059	17.2	
LaGrange	720	9	S
Lake	6,926	14.1	S
LaPorte	1,309	25.1	S
Lawrence	547	25	S
Madison	1,596	23.6	S
Marion	14,701	17.6	
Marshall	701	17.4	

County	Total Births	% Smoked	
Martin	119	21.8	
Miami	451	27.1	S
Monroe	1,229	16.3	
Montgomery	466	26.2	S
Morgan	873	23.1	S
Newton	155	28.4	
Noble	678	23.5	
Ohio	62	29	
Orange	239	25.9	
Owen	232	25	
Parke	205	30.7	S
Perry	233	32.6	S
Pike	135	25.2	
Porter	1,873	15.8	
Posey	242	22.3	
Pulaski	164	26.2	
Putnam	404	27.5	S
Randolph	321	24.9	
Ripley	396	22.2	
Rush	217	27.6	S
St.Joseph	3,706	13.4	S
Scott	293	31.1	S
Shelby	537	23.5	
Spencer	232	17.2	
Starke	280	29.3	S
Steuben	419	25.3	S
Sullivan	266	24.1	
Switzerland	126	27.8	
Tippecanoe	2,012	14.2	S
Tipton	200	18.5	
Union	74	28.4	
Vanderburgh	2,356	21.3	S
Vermillion	200	35.5	S
Vigo	1,297	28.1	S
Wabash	373	23.6	
Warren	94	17	
Warrick	641	15.1	
Washington	350	26.9	S
Wayne	857	27.1	S
Wells	381	18.6	
White	325	18.5	
Whitley	427	18.5	

SOURCE: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team.

"S" Significantly different from the state percent.

Percentages are calculated using total births in each county or county/race category.

The proportion of pregnant women smoking during pregnancy ranges from 5 percent to 35 percent by county.

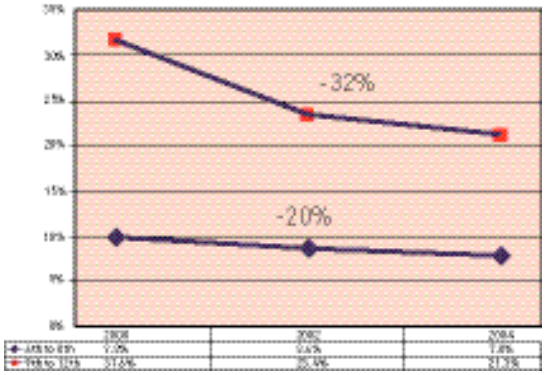
Chart 9: Smoking During Pregnancy in Indiana, 1998-2003

Rates among Hoosier moms continue to decline, although the rates are still nearly twice the national average.

Youth Smoking

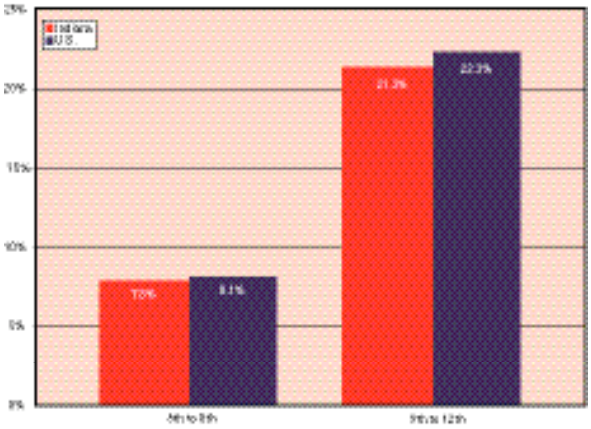
Approximately 21 percent of Indiana high school (9th to 12th grades) and 8 percent of middle school (6th to 8th grades) students report current cigarette use. This is a 32 percent decline among Indiana high school students since 2000. A decline of 20 percent was also seen among middle school students. Indiana's youth smoking rates are lower than the national average for the first time[83]. The greater decline in high school smoking occurred between 2000 and 2002, then the decrease s lowed while still significant between 2002 and 2004.

Chart 10: Indiana Youth Smoking, 2000-2004



For high school students the smoking rates dropped by 32% between 2000 and 2004. Middle school smoking rates declined by 20% from 2000 to 2004.

Chart 11: Current Smoking by Youth, Indiana vs. U.S., 2004

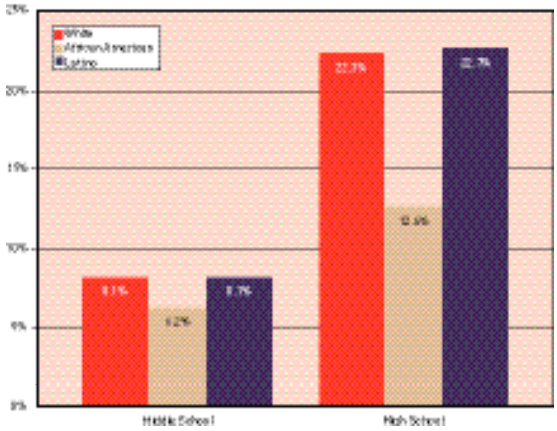


Indiana's youth smoking rates are lower than the national averages for the first time.

Smoking rates for middle school girls is higher than that for boys. However, smoking rates for high school girls (20%) and boys (23%) are similar to the sta te rates[84]. There are no significant differe nces in middle school smoking among race/ethnic groups as shown in *Chart 12: Indiana Youth Smoking by Race/Ethnicity,*

Middle and High School Smoking, 2004. There appear to be some differences between White and African American high school youth. The rate for White and Hispanic students is similar to the state average, while the rate for African Americans is lower. A similar trend is seen among middle school youth although not as dramatic.

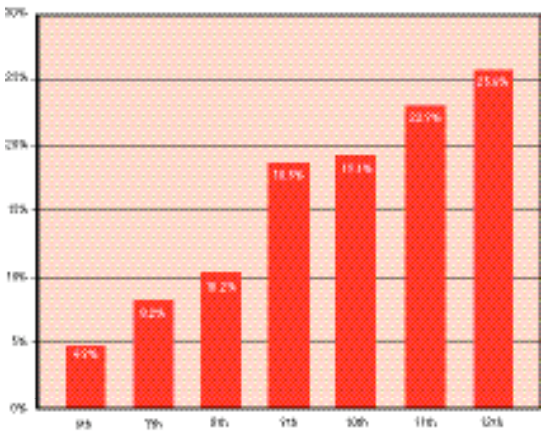
Chart 12: Indiana Youth Smoking by Race Ethnicity, Middle and High School 2004



Smoking rates among middle school youth do not vary by race for middle school youth. However, smoking rates among African American high school youth are lower than for White and Latino youth.

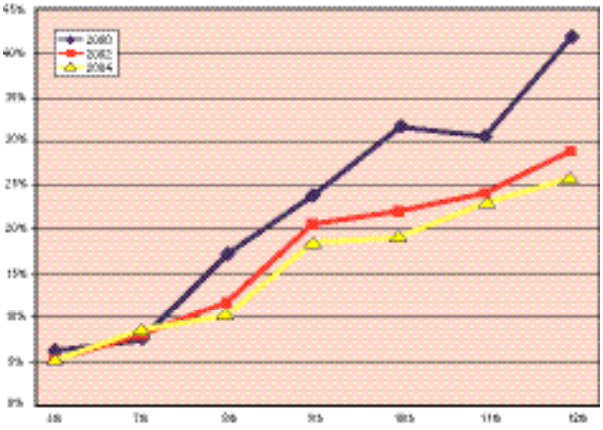
Smoking rates increase as a youth ages. As shown in *Chart 13: Indiana Youth Smoking by Grade, 2004,* approximately 5 percent of 6th grade students are current smokers increasing to 10 percent by the time students are 8th graders, then a jump to 19 percent of 9th and 10th grade students smoking, and then increasing to 25 percent when they are 12th graders. The increase occurs between the grades of 8th and 9th giving insight to the youth that need targeted interventions.

Chart 13: Indiana Youth Smoking by Grade, 2004



Smoking increases as youth age with rates ranging from 5% in 6th graders to 25% in 12th graders.

Chart 14: Indiana Youth Smoking by Grade, 2000-2004



Smoking rates have dropped the most among 12th graders between 2000 and 2004.

In comparing the smoking rates among grade levels for the years 2000, 2002 and 2004, one can see the significant decrease from 2000 for grades 8-12. The trend for grades 8-12 is similar

in 2002 and 2004, with 2004 being lower. The largest drop can be seen in the 12th and 10th grades, respectively. Rates at the 6th and 7th grade levels remain unchanged.

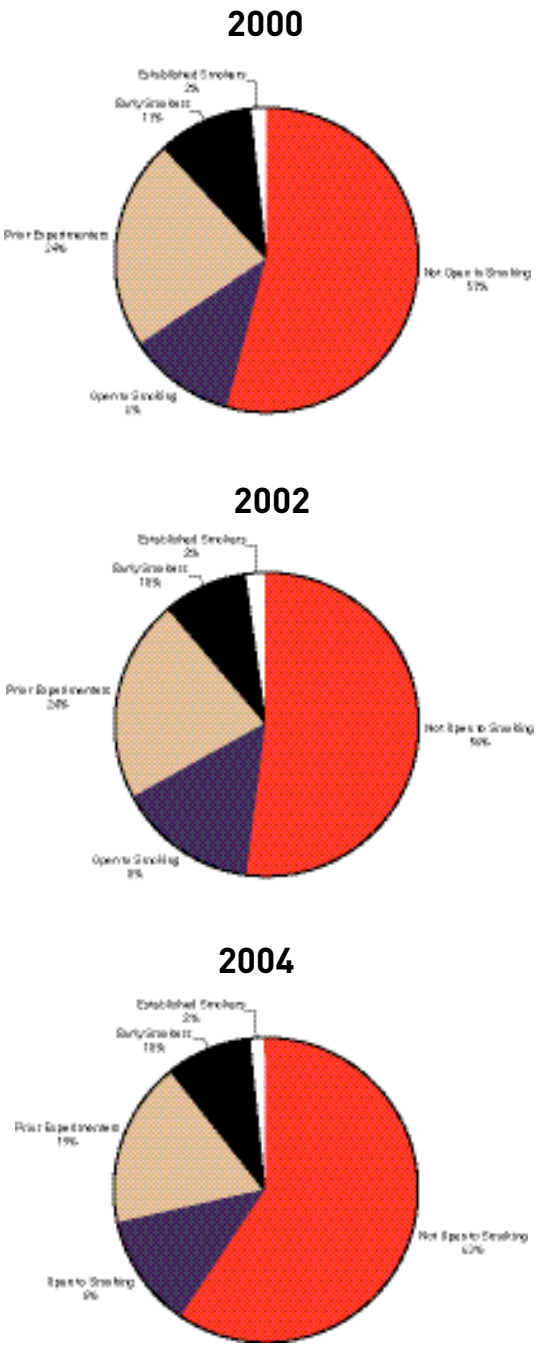
Susceptibility to Tobacco

Analysis of data on smoking uptake and cessation indicators suggest that Indiana youth are responding to local and state tobacco control programs that are funded through ITPC efforts. The percent of youth that report being "not open to smoking" increased significantly for both middle school and high school youth. By the definition of "not open to smoking", these results indicate that more Indiana high school students would not consider smoking in the future or when offered a cigarette by a friend, thus suggesting stronger anti-smoking attitudes that prevent smoking initiation.

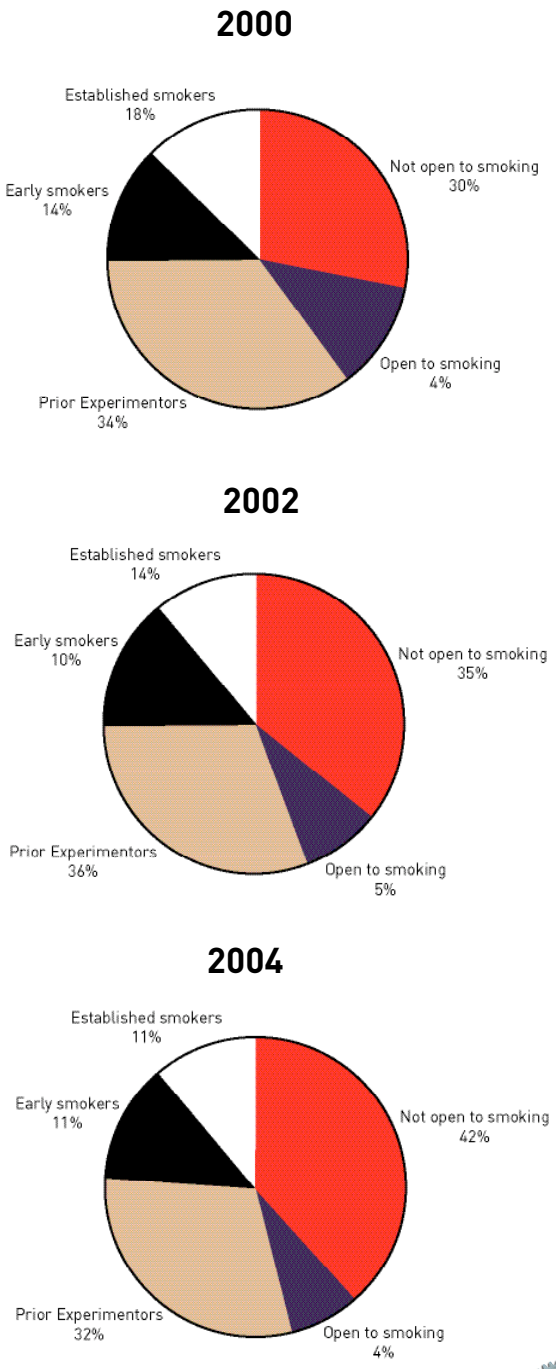
The proportion of middle school youth that report, "prior experimenting" with smoking significantly dropped from 2002 to 2004. While the percent of high school youth that report being an "established smoker" reduced to 10 percent with significant declines in 2002 and 2004.

Percentage of middle school students who reported being "prior experimenters" decreased significantly from 22 percent in 2002 to 18 percent in 2004

Charts 15, 16 and 17: Smoking Uptake, Middle School Students, 2000, 2002 and 2004



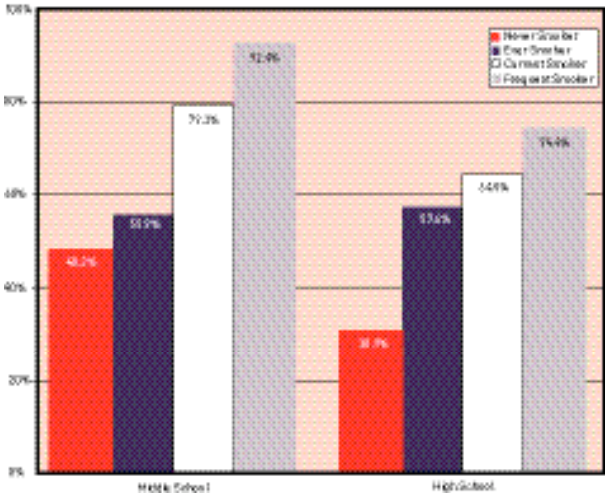
Charts 18, 19 and 20: Smoking Uptake, High School Students, 2000, 2002 and 2004



Influences

Home and social influences impact youth smoking. Youth that report living with someone who smokes are more likely to smoke themselves. Youth that have at least one friend that smokes are also more likely to have a history of smoking[85]. As the level of experience in smoking increases, the greater the proportion of youth reporting influence by others on their smoking status.

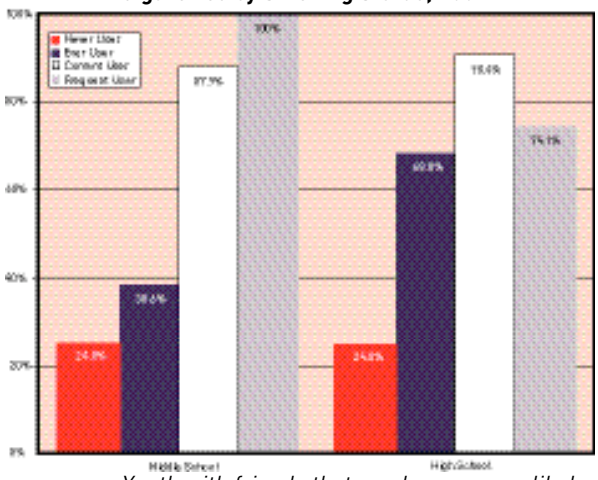
Chart 21: Youth Living with Someone who Smokes Cigarettes by Smoking Status, 2004



Youth living with someone that smokes are more likely to be current and frequent smokers.

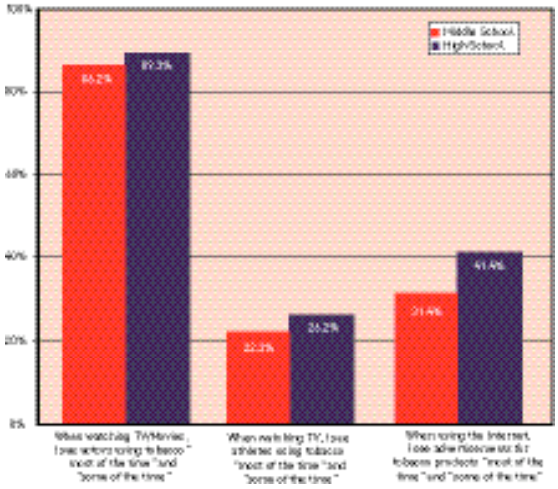
Percentage of high school students who reported being "not open to smoking" increased significantly from 30 percent in 2000 to 42 percent in 2004

Chart 22: Youth with One Friend who Smokes Cigarettes by Smoking Status, 2004



Youth with friends that smoke are more likely to smoke themselves.

Chart 23: Exposure to Pro-tobacco Messages among Current Smokers, 2004



Youth see pro-tobacco images mostly from actors on TV and in movies.

Media Exposure

Messages and images in the media glamorizing tobacco use have an influence on the social acceptability of smoking, especially by youth. Youth, never smokers and current smokers alike reported seeing these images in the media. Eight out of ten youth report seeing tobacco use by actors. Approximately one-fourth report seeing athletes use tobacco and one-third report seeing tobacco product advertisements while using the internet.

Brand Preferences

Exposure to tobacco marketing strongly influences the brand of cigarettes smoked by youth.

In 2004, among middle school smokers:
- Approximately one-third (36%) reported they smoked Marlboro
- Sixteen percent (16.5%) report no usual brand
- Sixteen percent (15.7%) smoke Newport
- Thirteen percent (13.3%) say they smoke another brand
- Twelve percent (11.9%) smoke Camel

In 2004, among high school smokers:
- Approximately half (52.4%) reported they smoked Marlboro
- Seventeen percent (17%) smoke Newport
- Thirteen percent (13.6%) smoke Camel

These data show that middle school smokers have not yet established the brand loyalty that high school smokers have developed to these three most heavily advertised brands of cigarettes.

For more data from the 2004 Indiana youth tobacco survey can be found throughout this report and in the 2004 Indiana YTS report at **www.in.gov/itpc/research.asp.**
The 2006 Indiana Youth Tobacco Survey will be conducted in the fall of 2006.

Other Tobacco use

While cigarettes are the preferred form of tobacco use in Indiana, other products are used such as spit or chewing tobacco, cigars, pipes, and bidis.

Spit Tobacco

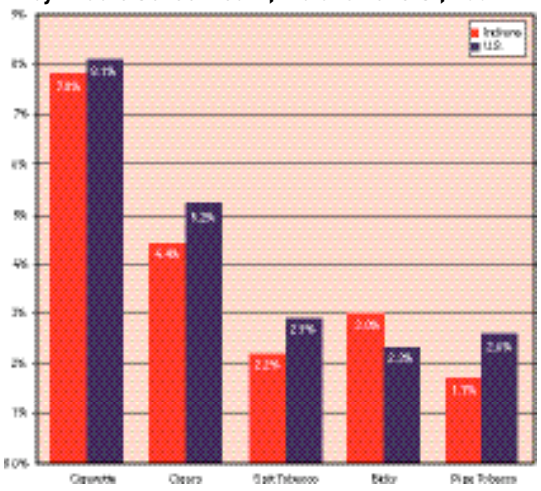
Spit tobacco, or smokeless tobacco, comes in two forms: moist snuff and chew. Snuff is a finely ground tobacco and is usually placed between the bottom lip and gum and held there. This is also referred to as "dipping". Chewing tobacco is shredded tobacco leaves placed between the cheek and gum. Spit tobacco contains 3,000 chemicals, 28 of them have been identified as cancer-causing agents including formaldehyde, nicotine, arsenic, cadmium, and polonium-210.

Approximately 17 percent of Hoosier adults have tried spit tobacco, and of those adults 22 percent use these tobacco products every day or some days[86]. This is similar to the U.S. rate of 22 percent of adults who currently use spit tobacco[87]. Of those Indiana adults who use spit or chewing tobacco every day or some days, one-fourth use less than one can per week and one-third use 1-2 cans per week and 16 percent use 3-4 cans of spit tobacco per week[88].

Approximately 3 percent of middle school and 12 percent of high school boys in Indiana currently use spit tobacco, these rates are similar to the national averages. The proportion of high school boys using spit tobacco is nearly five times that of girls.

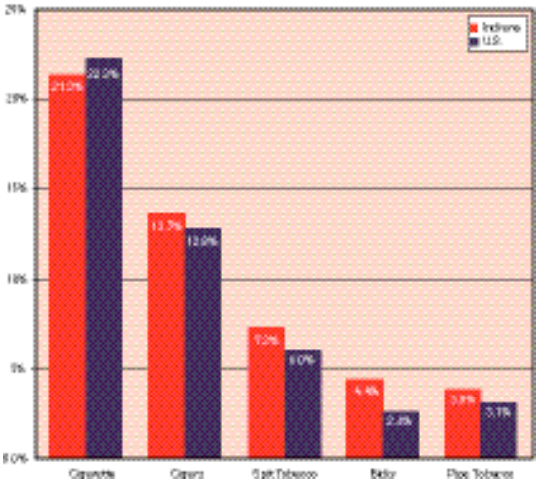
As illustrated in *Chart 24: Current use of all tobacco products by middle school youth, Indiana vs. U.S., 2004* and *Chart 25: Current use of all tobacco products by high school youth, Indiana vs. U.S., 2004,* spit tobacco use rates among middle school youth are lower than the rest of the nation, while the high school rates are higher.

Chart 24: Current Use of All Tobacco Products by Middle School Youth, Indiana vs. U.S., 2004



Hoosier middle school youth prefer cigarettes over other tobacco products. More Hoosier youth use bidis than other U.S. middle school youth.

Chart 25: Current Use of All Tobacco Products by High School Youth, Indiana vs. U.S., 2004



Hoosier high school youth prefer cigarettes as their forms of tobacco use but use rates of other products are higher than the U.S.

White and Hispanic high school youth have higher smokeless tobacco use rates than African American high school students, which is similar to the middle school rate for African Americans.

Health Effects of Spit Tobacco

Spit tobacco is not a safe alternate to cigarettes and is responsible for numerous health problems. Holding one pinch of spit tobacco in your mouth for 30 minutes gives the same amount of nicotine as smoking three to four cigarettes. Nicotine is absorbed more slowly in smokeless tobacco than from cigarettes[89]. The negative effects to using spit tobacco include bad breath, spitting and stained teeth. People who use spit tobacco are at risk of many health problems including cancers of the lip, esophagus, pharynx, larynx, pancreas and stomach. These cancers can form within only five years of regular spit tobacco use. Only one-half the number of persons diagnosed with oral cancer are alive five years after the diagnosis.[90]

Users are susceptible to mouth diseases such as leukoplakia, a disease of the mouth characterized by white patches and oral lesions on the cheeks, gums, and tongue[91]. Studies show that 60-78 percent of spit tobacco users have oral lesions. During the first 3 years of use, leukoplakia occurs in more than half of smokeless tobacco users. Spit tobacco also causes gum recession increasing risk of dental and root caries. Spit tobacco use also increases the risk of heart attack and other heart disease as the nicotine constricts veins leading to heart problems and high blood pressure.

Cigars and Bidis

Cigars contain the same toxic and cancer-causing compounds found in cigarettes and are not a safe alternative to cigarettes[92]. The number of new cigar smokers more than doubled between 1990 and 1998 after promotional activities for cigars increased after marketing efforts have promoted cigars as symbols of a luxuriant and successful lifestyle. Endorsements by celebrities, development of cigar-friendly magazines features of highly visible women smoking cigars, and product placement in movies have contributed to the increased visibility of cigar smoking in society[93].

In the U.S., an estimated 15 percent of students in grades 9–12 in the U.S. are current cigar smokers. Approximately 6 percent of middle school students in the U.S. are current cigar smokers.[94] Cigar smoking is more common among young males than females in these grades[94]. In Indiana, the rate of cigar use among middle school youth is 4.4 percent reporting regular use, while over 13 percent of high school youth currently smoke cigars[95].

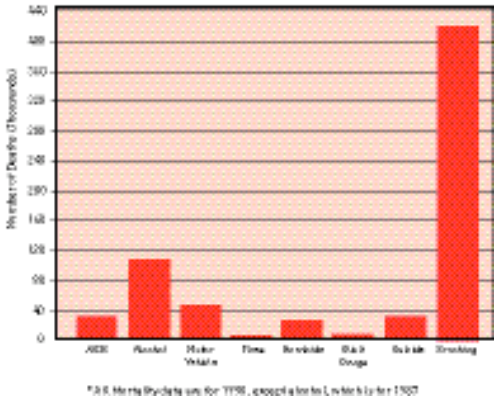
Regular cigar smoking is associated with an increased risk for cancers of the lung, oral cavity, larynx, and esophagus[96]. Heavy cigar smokers and those who inhale deeply may be at increased risk for developing heart and lung disease[97]. Risks from cigar smoking increase with increased exposure. Smoking three to four cigars daily can increase the risk of oral cancers to more than eight times that of a nonsmoker. Nicotine from cigar smoking is primarily absorbed through the lining of the mouth, as most cigar users do not inhale[98].

Bidis are small, thin hand-rolled cigarettes imported to the United States primarily from India and other Southeast Asian countries. They consist of tobacco wrapped in a tendu or temburni leaf, can be flavored or unflavored and may be secured with a colorful string. They have higher concentrations of nicotine, tar, and carbon monoxide than conventional cigarettes sold in the United States[99]. Approximately 3 percent of middle and 4 percent of high school youth currently use bidis. Use rates for cigars, pipes and bidis by Hoosier youth are similar to the national rates[100].

Deaths and Diseases Caused by Smoking

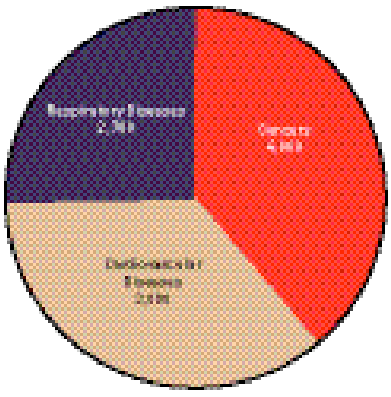
Smoking alone is responsible for an estimated 438,000 premature deaths in the United States annually with nearly 9,700 deaths in Indiana. On average, persons who smoke cut their lives short by 14 years[101]. Smoking is the major risk factor for cancers, heart diseases and strokes, the leading causes of death in the U.S. and Indiana.

Chart 26: Annual Deaths From Smoking Compared with Selected Other Causes of Death.



The number of deaths to tobacco far exceeds deaths by other causes.

Chart 27: Annual Deaths in Indiana Caused by Major Smoking-related Diseases



Cardiovascular diseases cause nearly as many tobacco-related deaths to Hoosiers than cancers[102]

The Health Consequences of Smoking: A Report of the Surgeon General (2004) states that "smoking remains the leading cause of preventable death and has negative impacts on people at all stages of life. It harms unborn babies, infants, children, adolescents, adults, and seniors". The main findings of the report describes the harmful effects of smoking on nearly every organ of the body, causing many diseases and reducing the health of smokers in general. It also reminds everyone that quitting smoking has immediate as well as long-term benefits, such as reducing risks for diseases caused by smoking and improving overall health. In addition, the report stresses that smoking cigarettes with lower machine-measured yields of tar and nicotine provides no clear benefit to health.

The Health Consequences of Smoking Report provides a list of diseases caused by smoking has been expanded to include abdominal aortic aneurysm, acute myeloid leukemia, cataract, cervical cancer, kidney cancer, pancreatic cancer, pneumonia, periodontitis, and stomach cancer. These are in addition to diseases previously known to be caused by smoking, including bladder, esophageal, laryngeal, lung, oral, and throat cancers, chronic lung diseases, coronary heart and cardiovascular diseases, as well as reproductive effects and sudden infant death syndrome. Smoking attributable death rate is 315 per 100,000 in Indiana. Smoking attributable mortality is twice the rate for Hoosier men (456 per 100,000) than for women (220 per 100,000).

Respiratory Health

Smoking is a known cause of chronic obstructive pulmonary disease (COPD), which includes chronic bronchitis and emphysema[103]. Smoking accounts for 90 percent of all COPD deaths in the U.S. According to the American Cancer Society's second Cancer Prevention Study, female smokers were nearly 13 times as likely to die from COPD as women who had never smoked. Male smokers were nearly 12 times as likely to die from COPD as men who had never smoked[104]. Indiana has a higher smoking attributable death rate due to COPD compared to the all-states average rate[105]. The smoking attributable death rate from all respiratory diseases is 87 per 100,000 in Indiana[106].

Coronary Heart Disease and Stroke

More than 61 million Americans suffer from some form of cardiovascular disease, including high blood pressure, coronary heart disease, stroke, congestive heart failure, and other conditions. Coronary heart disease and stroke are the main types of cardiovascular disease caused by smoking and are the leading causes of death in the United States[107]. Twenty-one percent of all coronary heart disease deaths in the U.S. are due to smoking[108]. The smoking attributable death rate for coronary heart disease in Indiana was 97 per 100,000 deaths in 2003[109].

Coronary heart disease results from atherosclerosis of the coronary arteries. Cigarette smoking releases toxins in the blood contributing to the development of atherosclerosis, a progressive hardening of the arteries caused by the deposit of fatty plaques and the scarring and thickening of the artery wall. Inflammation of the artery wall and the development of blood clots can obstruct blood flow and cause heart attacks or strokes.

Strokes are the third leading cause of death in the United States. Cigarette smoking is a major cause of strokes. The risk of stroke decreases steadily after smoking cessation. Former smokers have the same stroke risk as nonsmokers after 5 to 15 years[110].

Cancer

Cancer is the second leading cause of death and was among the first diseases causally linked to smoking. More than 30 percent of all cancers are due to smoking[111]. The 2004 Surgeon General's Report on the Health Consequences of Smoking adds more evidence to previous conclusions that smoking causes cancers of the oral cavity, pharynx, larynx, esophagus, lung, and bladder. The 2004 report also lists newly identified cancers caused by smoking, including cancers of the stomach, cervix, kidney, and pancreas and acute myeloid leukemia[112]. For smoking-attributable cancers, the risk generally increases with the number of cigarettes smoked and the number of years of smoking, and generally decreases after quitting completely.

Smoking causes about 90 percent of lung cancer deaths in men and almost 80 percent in women[113]. Men who smoke increase their risk of death from lung cancer by more than 23 times. Women who smoke increase their risk of dying from lung cancer by nearly 13 times[114]. In 1987, lung cancer surpassed breast cancer and is now the leading cause of cancer death among women.

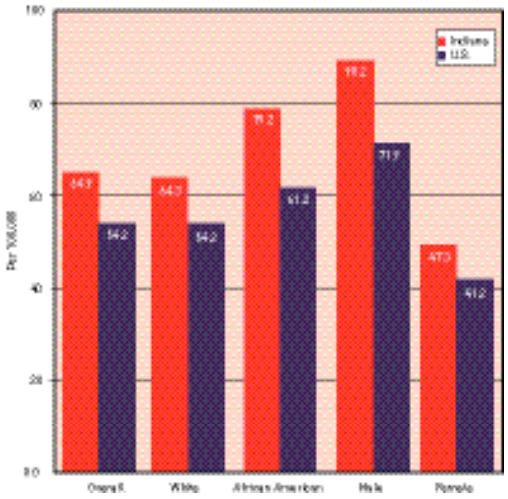
The lung cancer incidence rates in Indiana overall is 80.1 per 100,000 for the years 1999-2003. However, incidence rates for Indiana men (107.7 per 100,000) are much higher incidence rates for women at 60.6 per 100,000. These are higher than the 2003 incidence rates by gender nationally that show 78.5 per 100,000 cases among men and 51.3 per 100,000 women[115]. An average of 2,300 new cases of lung cancer occur in Indiana men each year, compared to an average of 1,600 new cases in Indiana females[115]. Lung cancer incidence rates among Whites are 80 per 100,000 compared to 89.9 per 100,000 for African Americans.

Lung cancer is the leading cause of cancer mortality in Indiana, killing an average of 3,900 Hoosiers per year between 1999 and 2003. Between 1999 and 2003, an average of 4,857 new cases of lung cancer were diagnosed each year[115].

Indiana's lung cancer mortality rates remain higher than the U.S. rates by 18 percent overall. When comparing these rates by race, the mortality rate among Hoosier African Americans is 29 percent higher than for all U.S. African Americans, and 18 percent higher among Hoosier Whites than compared to the U.S.[116].

Mortality rates among Hoosier men and women are also higher than U.S. rates by 15 percent for women and 25 percent for men as shown in *Chart 28: Lung and Bronchus Cancer Mortality Rates by Race, Gender, Indiana (1999-2003) vs. U.S. (2003).*

Chart 28: Lung and Bronchus Cancer Mortality Rates by Race, Gender, Indiana (1999-2003) vs. U.S. (2003).



In Indiana lung cancer mortality rates are higher for African Americans than for Whites. Mortality rates among Hoosier men and women are also higher than U.S. rates by gender.

Lung cancer incidence rates by county range from 45.0 per 100,000 to 123.7 per 100,000. The Indiana average is 80.6 per 100,000[117]. More than half of the counties have lung cancer incidence rates ower than the state average of 80.6 per 100,000.

Lung cancer mortality rates by county range from 36.1 per 100,000 to 101.8 per 100,000. The Indiana average is 65 per 100,000[116]. The lung cancer mortality rates are lower than the state average of 65 per 100,000 for approximately half of the counties.

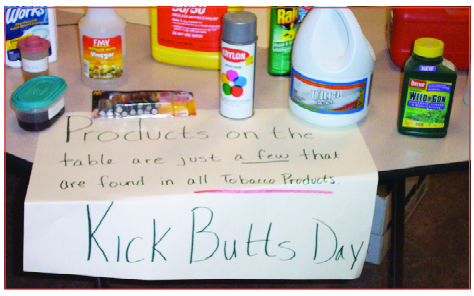


Table 3: Average Indiana Lung Cancer Incidence Rates by County, 1999 - 2003

County	Count	Rate
Adams	84	50.8
Allen	1,090	71
Bartholomew	264	72.5
Benton	53	102.2
Blackford	93	110
Boone	142	63.3
Brown	44	54.7
Carroll	59	53.2
Cass	189	84.4
Clark	495	100.1
Clay	177	116.4
Clinton	125	68.6
Crawford	55	93.9
Daviess	123	75.3
Dearborn	174	78.9
Decatur	108	82.9
DeKalb	125	65.7
Delaware	498	79.7
Dubois	93	45.4
Elkhart	584	71.2
Fayette	135	88.3
Floyd	326	90.9
Fountain	101	94.9
Franklin	69	60.8
Fulton	93	76.9
Gibson	144	74.9
Grant	352	82
Greene	176	89.3
Hamilton	424	64.9
Hancock	230	83.2
Harrison	145	85.8
Hendricks	365	79.6
Henry	233	78.5
Howard	357	77.8
Huntington	141	69.6
Jackson	204	94.2
Jasper	135	88.1
Jay	83	65.7
Jefferson	165	96.3
Jennings	117	89.5
Johnson	410	75.9
Knox	183	81
Kosciusko	255	69
LaGrange	102	68
Lake	1,913	76.1
LaPorte	474	80.1
Lawrence	241	89
Madison	699	91
Marion	3,653	95.5
Marshall	169	72
Martin	36	59.5
Miami	171	90.9
Monroe	326	71.5
Montgomery	156	75.6
Morgan	281	90.9
Newton	76	98.9
Noble	156	74.5
Ohio	31	96.2
Orange	81	72.4
Owen	102	87.9
Parke	85	83.5
Perry	86	80.5
Pike	63	80.1
Porter	479	68.5
Posey	118	85.1
Pulaski	47	58
Putnam	156	86.5
Randolph	128	78.7
Ripley	120	85.8
Rush	90	88.9
St. Joseph	137	123.7
Scott	181	83
Shelby	80	72.9
Spencer	1,065	78.8
Starke	118	88.6
Steuben	119	73.3
Sullivan	123	103.1
Switzerland	40	83.5
Tippecanoe	415	75
Tipton	65	68.9
Union	20	52.3
Vanderburgh	847	86.6
Vermillion	79	78.9
Vigo	510	90.5
Wabash	140	67.9
Warren	21	45
Warrick	210	81.5
Washington	116	85.1
Wayne	393	93.5
Wells	69	45.4
White	104	70.2
Whitley	111	69.1
Indiana	24,441	80.6

Source: Indiana State Department of Health — Indiana State Cancer Registry , June 2006

Rates are per 100,000 population age-adjusted to the 2000 U.S. Population Standard.

Forty-three counties have lung cancer incidence rates higher than state average of 80 per 100,000.

Table 4: Average Indiana Lung Cancer Mortality Rates by County, 1999 - 2003

County	Count	Rate
Adams	66	38.7
Allen	845	55.1
Bartholomew	206	57.1
Benton	35	64.2
Blackford	45	53.8
Boone	125	55.5
Brown	56	67.5
Carroll	54	48.6
Cass	150	66.2
Clark	421	85.7
Clay	110	71.7
Clinton	111	59.6
Crawford	41	72.6
Daviess	102	61.7
Dearborn	162	74.2
Decatur	88	67.5
DeKalb	102	53.8
Delaware	426	67.8
Dubois	86	42
Elkhart	461	56.3
Fayette	102	66.9
Floyd	256	71.4
Fountain	68	62.3
Franklin	40	36.1
Fulton	86	71
Gibson	101	52.4
Grant	290	67.3
Greene	132	66.9
Hamilton	324	50.7
Hancock	166	61.7
Harrison	120	72.2
Hendricks	270	58.5
Henry	198	66.3
Howard	300	65.5
Huntington	125	59.8
Jackson	144	66.2
Jasper	103	67.7
Jay	75	58.7
Jefferson	119	70.6
Jennings	105	81.6
Johnson	341	63.4
Knox	143	61.5
Kosciusko	200	54.6
LaGrange	79	52.6
Lake	1,566	62.3
LaPorte	393	66.3
Lawrence	192	70.5
Madison	528	68.4
Marion	2,957	77.4
Marshall	135	57.2
Martin	35	58.8
Miami	118	63.2
Monroe	278	61
Montgomery	115	55.7
Morgan	231	75.6
Newton	62	82.1
Noble	151	72
Ohio	29	91.1
Orange	84	76
Owen	88	77.2
Parke	72	70.8
Perry	63	58.5
Pike	53	67.3
Porter	385	55.7
Posey	85	61.6
Pulaski	35	43.4
Putnam	138	77.2
Randolph	96	58.4
Ripley	69	48.9
Rush	74	73.2
St. Joseph	112	101.8
Scott	143	66.1
Shelby	61	56
Spencer	845	61.8
Starke	106	79.9
Steuben	97	60.4
Sullivan	95	79.7
Switzerland	35	71.6
Tippecanoe	343	62
Tipton	53	55.8
Union	14	37.8
Vanderburgh	673	67.8
Vermillion	66	65.5
Vigo	447	78.5
Wabash	123	59
Warren	29	60.3
Warrick	175	69.4
Washington	94	68.7
Wayne	313	73.9
Wells	69	44.8
White	82	55.6
Whitley	90	56.2
Indiana	19,676	64.9

Source: Indiana State Department of Health — Indiana State Cancer Registry , June 2006

Rates are per 100,000 population age-adjusted to the 2000 U.S. Population Standard.

Forty-seven (47) counties with mortality rates are higher than state average of 65 per 100,000.

Cessation

Quitting smoking is difficult to do, and with an estimated 1.2 million adult smokers in Indiana, there are many people that need help quitting. Despite the number of Hoosier smokers almost half (48%) tried to quit smoking during the past year based on most current data available. In addition, many Hoosiers express desires to quit smoking:

- Eighty-three percent (83%) of current smokers expect to quit at some time in their lives.
- Fifty-eight percent (58%) planning to quit in the next six months.
- Twenty-four percent (24%) in the next thirty days.

Intentions to quit smoking indicate that many Hoosiers are thinking about changing their behaviors and moving toward a readiness to quit tobacco use. Several factors influence whether Hoosier adults have intentions to quit smoking or will attempt to quit, as well as their likelihood to succeed in quitting.

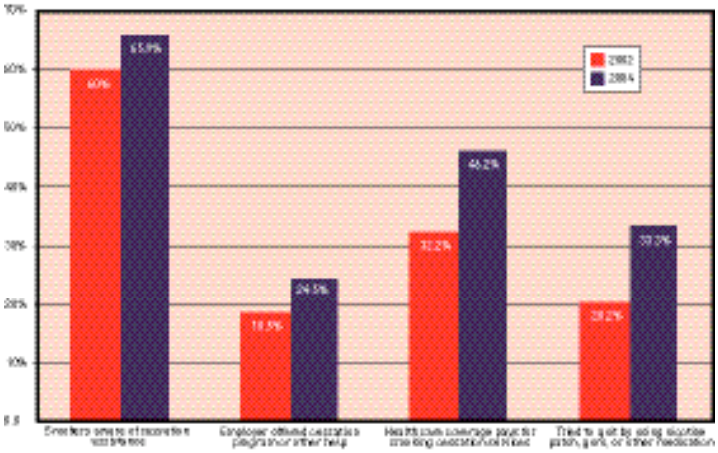
- Males were 40 percent less likely than females to have tried to quit smoking in the past 12 months.
- Adults in households with some kind of smoking rule (partial or full house ban) were 57 percent more likely to try to quit smoking and 197 percent more likely to successfully quit smoking. Sixty-five percent of Hoosiers prohibit smoking in their homes in 2004.
- Heavy smokers were 43 percent less likely than light smokers to try to quit smoking.
- The youngest age group, 18–34 year olds, as well as the oldest, 55 years and older, were both significantly more likely than 35- to 54-year-olds to have successfully quit smoking.

Awareness of Cessation Resources

Getting help in quitting smoking allows smokers who want to quit to become non-smokers. Awareness of the resources to quit smoking is an important step toward cessation. More Hoosier smokers reported availability of smoking cessation help at their workplace and coverage of smoking cessation services by the health insurance in recent years. It is not clear from these data whether these increases are due to more employees offering cessation help, more health insurance policies covering smoking cessation or smokers becoming more aware of these resources. Even more promising data show that more smokers have tried to use nicotine replacement therapies in order to quit smoking in 2004 than did in 2002. Since the use of nicotine replacement therapies involves substantial out-of-pocket costs to smokers, this trend suggests that Hoosier smokers are becoming more committed to quitting.

In 2006, Hoosiers had a new resource to help them quit smoking, the Indiana Tobacco Quitline. Launch on March 22, 2006, the Quit Line has been available for all Hoosiers, free, for help in quitting smoking through a telephone-based counseling sessions, in addition to resource and referral information in the local community. See **Indiana Tobacco Quit Line** on page 86.

Chart 29: Smokers' Awareness of cessation resources



There has been a significant increase in awareness of cessation resources among smokers between 2002 and 2004.

Physician Consultation and Advice

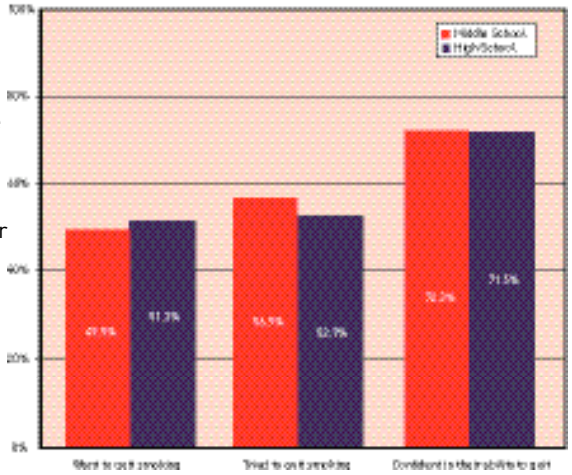
In 2005, nearly 75 percent of adults reported having seen either a doctor, nurse, or other health care professional for themselves in the past year. The most common type of assistance offered to smokers by their health care providers was a medication prescription (33 percent in 2004, including nicotine patch, gum, nasal spray, and pills). However, about a quarter of the physicians also advised smokers to set a quit date, and a similar number of physicians provided cessation material. The role of health care professionals in motivating smokers to quit is significant. Research shows that smokers who received advice from a physician were 2.5 times more likely to want to quit smoking than those not receiving advice from their doctors[118].

Youth also want to quit smoking and need help, however data from 2004 indicate one in ten high school smokers (10.3%) participated in cessation programs. The rate of participation in cessation programs for middle school students was 7 percent in 2004. Findings suggest that much more can be done to raise young smokers' awareness of cessation resources, and encourage participation in cessation programs to actualize the intent to quit into permanent cessation.

Youth Cessation

Young smokers also want to quit smoking. In 2004, approximately half of current youth smokers want to quit smoking (49.5%-middle school; 51.3% -high school). More than half have tried in quit smoking and seven out of ten current smokers are confident in their ability to quit smoking.

Chart 30: Cessation characteristics of youth smokers, 2004



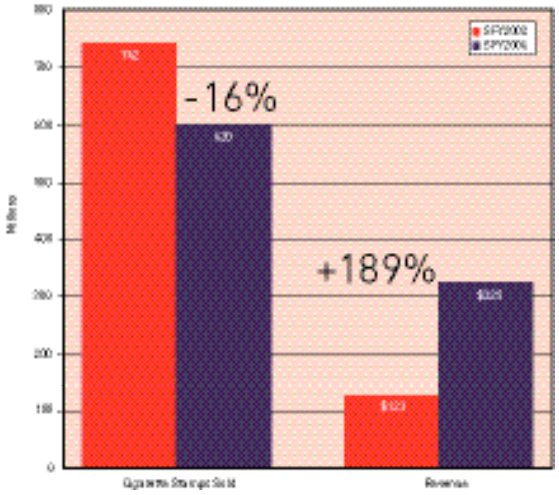
Most youth are confident about their ability to quit smoking.

Cessation services are available throughout all of Indiana's at the local community level in addition to the services provided by the Indiana Tobacco Quitline.
Visit **www.itpc.in.gov/community.asp** to find the coalition working in your community.

Cigarette Consumption

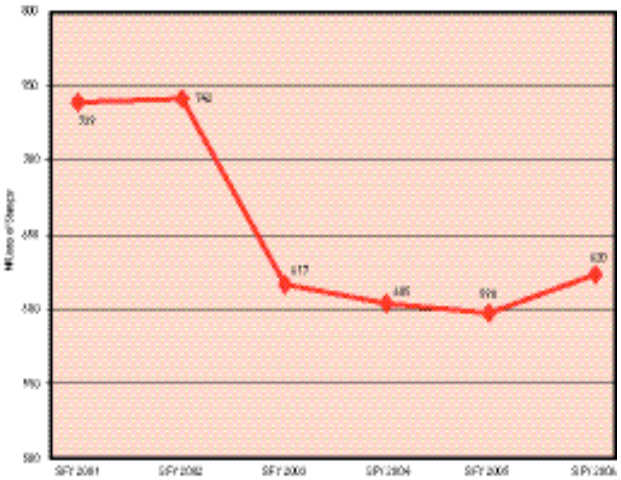
Cigarettes smoked by Hoosiers can be estimated through the number of cigarette tax stamps sold to tobacco retailer distributors. Data on tax stamp sales are collected through the Indiana Department of Revenue. While there has been an overall decline in the number of cigarette stamps sold since SFY 2002, the stamps sold in SFY 2006 was slightly higher than the number sold in SFY 2005. In SFY 2006, 620 million cigarette stamps were sold in Indiana, as illustrated in *Chart 31: Indiana Cigarette Consumption, SFY 2002-2006*. While the number of stamps sold declined 16% overall, there was a 3% increase from SFY 2005 to SFY 2006. State revenue collected increased by 189% since SFY 2002.

Chart 31: Indiana Cigarette Consumption and Tax Revenue, SFY 2002-2006



In Indiana, cigarette taxes have decreased cigarette smoking and increased state revenues.

Chart 32: Indiana Cigarette Consumption SFY 2002 to SFY 2006



The dramatic decrease occurred between SFY 2002 and SFY 2003 due to the tax increase of 40-cent increase that took effect July 1, 2002, bringing Indiana's tax to 55.5 cents per pack. However, Indiana's tax is lower than the current average cigarette tax for all states is 95.3 cents. The impact of the tax on cigarette consumption has slowed since SFY 2003.

Tobacco Control Policy

Strong public health policy change has been demonstrated as an effective strategy to change social norms regarding tobacco use and to combat the impact tobacco takes on our society.

Tobacco control policies include:

- Increasing tobacco taxes
- Protecting citizens and workers from exposure to secondhand smoke
- Funding comprehensive tobacco control programs
- Providing cessation coverage through health plans and programs
- Authorizing the FDA to regulate all tobacco products
- Ensuring strong youth access laws and enforcing those laws
- Reducing tobacco advertising, promotion, and marketing
- Regulating the manufacturing of fire safe cigarettes

Increasing Tobacco Taxes

Cigarette taxes are one of the most effective tools to reduce smoking. The CDC's Guide to Community Preventive Services strongly recommends increasing the unit price for tobacco products as a strategy to increase tobacco cessation and reduce tobacco use initiation by youth. Health economists have shown that increasing the price of cigarettes causes a reduction in smoking. Numerous U.S. Surgeon General reports have concluded that an optimal level of excise taxation on tobacco products will reduce smoking rates, tobacco consumption and the long-term health consequences of tobacco use.

Economic research studies currently conclude that every 10 percent increase in the real price of cigarettes reduces adult smoking by about 4 percent and teen smoking by roughly 7 percent[119]. There is strong evidence that youth are more responsive to price increases than adults. Youth are up to three times more sensitive to price than adults while younger adults (18-24) are about twice as sensitive to price than older adults[120]. Recent studies conclude that the

greatest impact of price increases is in preventing the transition from youth experimental smoking to regular (daily) smoking. Considering 90 percent of smokers start as teenagers, a group highly sensitive to price, higher taxes can sharply reduce youth smoking. A reduction in youth smoking will influence a long-term decrease in adult smoking.

Increasing cigarette taxes is a win-win-win. Fifteen years of research has shown that as the price of cigarettes goes up, fewer children start smoking, and more adults and teens quit. It's a health win for keeping Indiana kids from becoming daily smokers and to help adults reduce and quit their addiction. It's a fiscal win that raises needed revenue. It's a public win because cigarette taxes receive broad public support.

Table 5: State Cigarette Excise Taxes

CENTS PER PACK
Overall All States' Average: 95.3 cents

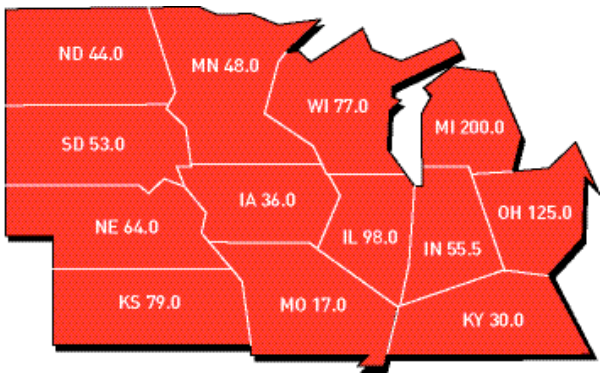
Rank	State	Tax	Rank	State	Tax
1	Rhode Island	246	27	New Hampshire	80
2	New Jersey	240	28	Kansas	79
3	Washington	202.5	29	Wisconsin	77
4	Maine	200	30	Utah	69.5
4	Michigan	200	31	Nebraska	64
6	Alaska	180	32	Wyoming	60
7	Vermont	179	33	Arkansas	59
8	Montana	170	34	Idaho	57
9	Connecticut	151	35	Indiana	55.5
9	Massachusetts	151	36	Delaware	55
11	New York	150	36	West Virginia	55
12	Texas	141	38	South Dakota	53
13	Hawaii	140	39	North Dakota	44
14	Pennsylvania	135	40	Alabama	42.5
15	Ohio	125	41	Georgia	37
16	Minnesota	123	42	Iowa	36
17	Arizona	118	42	Louisiana	36
17	Oregon	118	44	North Carolina	35
19	Oklahoma	103	45	Florida	33.9
20	District of Columbia	100	46	Kentucky	30
20	Maryland	100	46	Virginia	30
22	Illinois	98	48	Tennessee	20
23	New Mexico	91	15	Ohio	125
24	California	87	49	Mississippi	18
25	Colorado	84	50	Missouri	17
26	Nevada	80	51	South Carolina	7

The all-state cigarette tax average of 95.3 cents

The July 1, 2002 Indiana tripled its tax to 55.5 cents and at the time brought Indiana closer to other states. The 2002 tax increase has had an impact on decreasing cigarette consumption and increased revenue, however that impact has diminished. Currently, 34 states have higher cigarette taxes than Indiana, and we rank behind Michigan, Illinois, and Ohio. Illinois has a state cigarette tax of 98 cents. In addition, Cook County, Illinois has an additional $2.00 tax on cigarettes and the city of Chicago has a 68-cent cigarette tax. This brings the overall cigarette tax for the city of Chicago to $3.66. The overall All-States' average for state cigarette taxes is 95.3 cents[121].

In 2005, twelve states raised their cigarette taxes and two states have already increased them in 2006. Indiana's border states have also seen tax increases. Kentucky increased its tax from 3-cents to 30-cents and Ohio more than doubled its tax from 55-cents to $1.25 per pack. In 2004, Michigan increased its tax from 75-cents to $2.00.

Figure 3: Surrounding States Tobacco Taxes



Indiana's tax is lower than all of its border states, except Kentucky, with three border states increasing taxes in 2004 and 2005.

Increasing state cigarette taxes will not hurt tobacco farmers or lower-income smokers. A state cigarette tax impacts state smoking levels and cigarette sales while at the same time raising revenue for the state. But these increases have a smaller impact on the overall demand for American-made cigarettes or American-grown tobacco leaf. State smoking declines play a relatively small role in the overall demand for U.S. tobacco leaf and American-made cigarettes. Low-income smokers are much more likely to quit because of state cigarette tax increases than higher income smokers. Consequently this offers one of the best ways to help low-income families that currently suffer health and

economic costs from smoking-caused diseases. State cigarette tax increases give many current smokers a "tax cut." Those who quit will end up saving all the money they used to spend on cigarettes. That money in term will be spent on other goods that stimulate the economy.

Tobacco taxes still remain one of the strongest interventions to decrease smoking. If Indiana were to increase its cigarette tax by 50 cents, we could expect to see[122]:

- Fewer Hoosiers smoking: 24,000 adults and 51,400 youth
- Thousands of Hoosier youth saved from an early death by not smoking – 16,400 youth
- Produce healthier babies, with 8,000 smoking-affected births avoided over the next five years and a saving $11.4 million over five years in smoking-related pregnancy and birth health care costs, as fewer women will smoke during pregnancy
- Save more than $ 1 billion from long term health savings and increase in state revenue of $206 million

Protecting Citizens and Workers from Exposure to Secondhand Smoke

Indiana has experienced an amazing level of local smoke free air ordinance activity during the past year. As of June 30, 2006, 23 communities has passed some local smoke free air law. Fifteen of those laws are strong public health policy and follow the guidelines outlined by the U.S. Surgeon General in eliminating exposure from secondhand smoke from the indoor places that the respective ordinances covers. Unfortunately, the leaders in eight of these communities did not pass a policy following the recommended guidelines. Indiana has made great strides in protecting Hoosiers from secondhand smoke exposure, and was recognized by the Americans for Nonsmokers' Rights as the state with the third most local smoke free air policies passed in 2005. In 2006, more than one-third (36%) of all Hoosiers covered by one of these local communities laws, an increase from 3 percent in 2000. We've made great progress, but there is much to do. The following descriptions briefly explain the ordinances in these communities.

Avon:
The Avon ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Avon ordinance becomes effective on September 1, 2006.
To read the ordinance in full, visit **http://www.avongov.org/egov/docs/1151524062910.htm**

Bloomington:
In Bloomington, smoking is not allowed in public places and places of employment, including restaurants, bars, private clubs and outdoor seating areas. The Bloomington Ordinance became effective on August 1, 2003 for all places except bars. On January 1, 2005, bars became smoke free.
To read the ordinance in full, visit **http://bloomington.in.gov/egov/docs/1070886661_64712.pdf**

Carmel:
The Carmel ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Carmel ordinance became effective on March 5, 2006.
To read the ordinance in full, visit **http://www.ci.carmel.in.us/government/nosmoking/No%20Smoke%20Areas%20Ordina-nce.pdf**

Columbus:
The Columbus ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Columbus ordinance became effective on February 1, 2006.
To read the ordinance in full, visit **http://www.columbus.in.gov/pdf/Enforcement%20Ordinance2005.pdf**

Delaware County:*
The Delaware County ordinance requires public places and places of employment to be smoke-free. The ordinance allows for restaurants and bars to have separate smoking rooms. Private clubs are exempt from the ordinance. Based on the findings of the 2006 U.S. Surgeon

General's report, this ordinance is ineffective at protecting the health of the workers from secondhand smoke exposure in establishments that have designated smoking rooms. The Delaware County ordinance became effective on June 21, 2006. To read the ordinance in full, visit **http://co.delaware.in.us/county/uploads/smoking_ordinance.pdf**

Evansville:*
The Evansville ordinance only requires non-smoking areas in workplaces and public places. Smoking and nonsmoking sections are ineffective at protecting the health of workers from secondhand smoke exposure in the venues that are covered by this ordinance, according to one of the conclusions reached in the recent report of the U.S. Surgeon General. (The ordinance becomes effective on January 2, 2007.)

Franklin:
The Franklin ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Franklin ordinance* became effective on February 1, 2006. To read the ordinance in full, visit **http://www.franklin-in.gov/egov/docs/1152128211_383056.pdf**

Fort Wayne:*
The Fort Wayne ordinance required all enclosed public places to be smoke free. However, smoking is allowed in restaurants with a separate smoking room and a separate entrance. Private clubs, taverns, and bowling alleys are exempt from the ordinance. The ordinance became effective on January 1, 1999. Based on the findings of the 2006 U.S. Surgeon General's report, this ordinance is ineffective at protecting the health of the workers from secondhand smoke exposure in establishments that have designated smoking rooms.To read the ordinance in full, visit **http://www.amlegal.com/nxt/gateway.dll/?f=templates&fn=default.htm** and click on General Regulations.

Greenfield:
The Greenfield ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Greenfield ordinance became effective on March 1, 2006. To read the ordinance in full, visit **http://www.greenfieldin.org/egov/docs/1130963128_145477.pdf**

Greenwood:
The Greenwood ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Greenwood ordinance became effective on April 22, 2006. To read the ordinance in full, visit **http://www.greenwood.in.gov/egov/docs/1143557101_997924.pdf**

Indianapolis:
The Indianapolis ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Indianapolis ordinance became effective on March 1, 2006.
To read the ordinance in full, visit **http://www.indygov.org/NR/rdonlyres/egu47gtmmatjj5alrhlx2hogjcffml3bzuycrcd4t7u3zu4d6gg2f4rh33lhvgjrcsb7u2aq35h3g46lzf44dne56wb/Prop045.pdf**

Jeffersonville:
The Jeffersonville ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Jeffersonville ordinance became effective on June 14, 2006.

Lawrence:
The Lawrence ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Lawrence ordinance became effective on July 1, 2006.

Madison:
The Madison ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Madison ordinance will become effective on August 1, 2006.

Monroe County:
In Monroe County, smoking is not allowed in public places and places of employment, including restaurants, bars, private clubs and outdoor seating areas. On February 1, 2006, the Monroe County ordinance took effect to mirror Bloomington. To read the ordinance in full, visit **http://www.co.monroe.in.us/legal/county-code/370.pdf**

Morgan County:*
The Morgan County ordinance only covers restaurants and allows for these options: 1) be 100% smoke free; 2) allow smoking in a second room that has its own air filtration system for heating and cooling and is of equal size or smaller than the non-smoking area; or 3) to not allow children into the facility. The ordinance became effective on January 1, 2005.

Seymour:
The Seymour ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Seymour ordinance became effective on July 21, 2006. To read the ordinance in full, visit **http://www.seymourcity.com/pdf_files/Ord4_2006.pdf**

Shelbyville:*
The Shelbyville ordinance requires public places and places of employment to be smoke-free. The ordinance allows for restaurants and bars to have separate smoking rooms. Private clubs are exempt from the ordinance. Based on the findings of the 2006 U.S. Surgeon General's report, this ordinance is ineffective at protecting the health of the workers from secondhand smoke exposure in establishments that have designated smoking rooms. The Shelbyville ordinance becomes effective on September 1, 2006. To read the ordinance in full, visit **http://www.cityofshelbyvillein.com/images/Department%20of%20Law/062564.pdf**

Speedway:
The Speedway ordinance requires all public places and places of employment, including restaurants to be smoke free. Bars and private clubs are exempt from the ordinance. The Speedway ordinance becomes effective on September 1, 2006.

St. Joseph County:*
The St. Joseph County ordinance requires public places and places of employment to be smoke free. The ordinance allows restaurants to have smoking rooms. Hardship exemptions exist for small businesses. Bars and private clubs are exempt from the ordinance. Based on the findings of the recent U.S. Surgeon General's report, this ordinance is ineffective at protecting the health of the workers from secondhand smoke exposure in establishments that have designated smoking rooms. Furthermore, the so-called "hardship exemptions" permitted by this ordinance undermine the effectiveness of the ordinance and arise from a common misconception that smokefree workplace laws have a fiscal impact. The ordinance became effective on April 10, 2006.

West Lafayette:
The West Lafayette ordinance requires public places and places of employment, including restaurants and bars to be smoke free. Private clubs are exempted from the ordinance. The ordinance becomes effective on July 1, 2007. To read the ordinance in full, visit **http://ordlink.com/codes/westlaf/index.htm** and click on General Regulation.

Vanderburgh County:*
The Vanderburgh County ordinance requires public places and places of employment to be smoke-free. The ordinance allows for restaurants and bars to have separate smoking rooms. Private clubs are exempt from the ordinance. The exemption for bars and taverns with smoking rooms will end in 2009. Based on the findings of the 2006 U.S. Surgeon General's report, this ordinance is ineffective at protecting the health of the workers from secondhand smoke exposure in establishments that have designated smoking rooms. The ordinance becomes effective on January 2, 2007. To read the ordinance in full, visit **http://www.vanderburghgov.org/docs/co_05-06-009__non_smoking.doc**

Vigo County:*
The Vigo County ordinance requires public places and places of employment to be smoke free. It allows restaurants to have separate smoking rooms. Based on the findings of the 2006 U.S. Surgeon General's report, this ordinance is ineffective at protecting the health of the workers from secondhand smoke exposure in establishments that have designated smoking rooms. Bars are private clubs are exempt from the ordinance. There is a 5 year moratorium on revisiting the ordinance. The ordinance becomes effective on July 1, 2007.

* Does not meet the conclusion from The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Surgeon General's Report, 2006, that states, "eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke."

Fundamentals for Smoke Free Air Policy Development for Hoosier Communities

In 2005, state tobacco control partners developed the "Fundamentals for smoke free air policy development for Hoosier communities", based on the national model endorsed by organizations including: American Cancer Society, American Heart Association, American Lung Association, Americans for Nonsmokers' Rights, Campaign for Tobacco-Free Kids, the Praxis Project, the Tobacco Technical Assistance Consortium, Tobacco Control Legal Consortium, National African American Tobacco Prevention Network, National Latino Council of Alcohol and Tobacco, and Asian Pacific Partners for Empowerment and Leadership[123].

Indiana's version of the Fundamentals has been endorsed by the American Cancer Society, American Heart Association, American Lung Association of Indiana, Hoosier Faith and Health Coalition, Indiana Academy of Family Physicians, Indiana Latino Institute, Indiana Minority Health Coalition, Indiana Public Health Association, Indiana State Medical Association, and the ITPC Executive Board.

The Fundamentals are recommended guiding principles for developing and implementing effective smoke free policies that help achieve the goal of saving people's lives from the disease and death caused by secondhand smoke. These guidelines have been excerpted and adapted from a publication called "Fundamentals of Smoke free Workplace Laws," a smoke free air policy document that was collaboratively formulated by tobacco control partners at the national level. The principles are considered "best policy practice" for smoke free air policies and are based on the experiences and lessons learned from tobacco control advocates throughout the country over several decades.

The ultimate goal is to protect Hoosiers from exposure to secondhand smoke, to create healthier, thriving communities, and to help empower citizens to understand the health hazards they face from secondhand smoke and to expect that they will not be subjected to this unnecessary harm in workplaces or public places. The objective is not to simply "get a law passed." It is important to remember that this process takes time, sometimes years, and persistence.

Policy Planning Guidelines

- Start with the model smoke free air ordinance
- Develop clear definitions
- Avoid the "minors only" trap
- Avoid Accommodation: such as ventilation, smoking rooms and sections, red light/ green light
- Avoid hours provisions
- Avoid consent provisions
- Minimize exemptions
- Pursue smoke free workplaces, not just smoke free restaurants
- Avoid hardship exemptions
- Avoid long phase-in provisions
- Work from the inside out
- Remember the goal is a smoke free environment, not simply the passage of a law

There are over 2,200 municipalities in the U.S. with local laws in effect that restrict where smoking is allowed. These include some of the largest cities, such as New York City, Los Angeles, San Diego, Dallas, San Francisco, and Boston. Eighteen states have state laws that require 100% smoke free workplaces, and/or restaurants, and/or bars[124]. As of July 1, 2006, 44.5% of the US population is protected from exposure to secondhand smoke by a strong local or state smoke free regulation[125]. States include: California (Restaurants and Bars); Colorado (Restaurants and Bars); Connecticut (Restaurants and Bars); Delaware (Workplaces, Restaurants, Bars); District of Columbia (Workplaces Restaurants, and Bars effective 1/1/07); Florida (Workplaces and Restaurants); Hawaii (Workplaces, Restaurants, and Bars effective 11/17/06); Idaho(Restaurants); Maine(Restaurants and Bars); Massachusetts (Workplaces, Restaurants, Bars); Montana (Workplaces, Restaurants ,Bars effective 10/1/09); New York (Workplaces, Restaurants, Bars); North Dakota (Workplaces); Rhode Island (Workplaces, Restaurants, Bars); South Dakota (Workplaces); Vermont (Restaurants and Bars); Washington (Workplaces, Restaurants, Bars);

New Jersey (Workplaces, Restaurants, and Bars); Utah (Workplaces and Restaurants (Bars effective 1/1/2009)).

In addition, several countries have smoke free public places these include Ireland, Norway, Sweden, New Zealand, Malta, Uganda, and Bhutan, Italy, Quebec, Canada, Scotland, Bermuda, and Spain.

Several Indiana cities and counties have passed smoke free policies for government buildings and facilities, and a number of school districts expanded their smoke free building policy to include all school property and sponsored events. The current lists of smoke free policies by venue can be found the Appendix as well as by county in the Coalition pages beginning on page 115.

In many communities hospitals and health care facilities are leading the charge and setting the example in their community. In 2005, 36 facilities went smoke free on hospital grounds, another 30 hospital and major health centers implementing tobacco free campuses in 2006, and so far eight campuses are schedule for 2007.

In June 2006, ITPC collaborated with Indiana Rural Health Association (IRHA) to honor healthcare facilities that provide smoke-free campus locations for Indiana's rural populations through the second annual Rural Indiana Smoke-Free Environment (R.I.S.E.) awards. Nine healthcare providers received this special recognition as part of the IRHA annual meeting.

This honor recognizes smoke-free health care facilities serving all rural areas of the state; the award signifies a commitment from ownership, management and staff to take the necessary steps to lead Hoosiers toward a healthier Indiana. In order to qualify for the award, the applying facility must show evidence of a 100 percent smoke-free policy in all buildings, on all grounds and in all organization-operated vehicles. The facility also submitted an explanation of the process through which the policy was achieved and documentation of signage or other forms of enforcement. The R.I.S.E awards arepresented annually to all newly qualifying facilities in Indiana.

Recipients of 2006 Rural Indiana Smoke-Free Environment (R.I.S.E.) awards are:

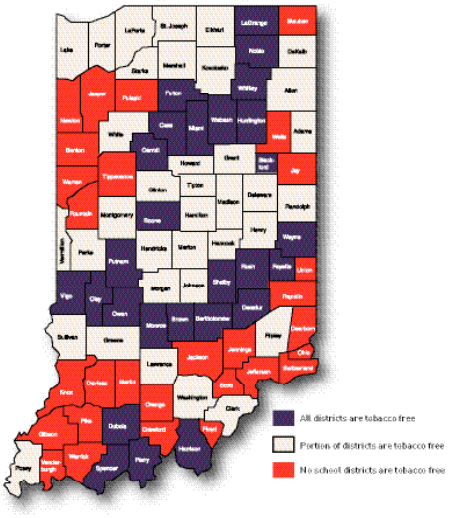
Award Recipient	City/Town	County
Bloomington Hospital	Bloomington	Monroe
St. Mary's Health System	Evansville	Vanderburgh
Daviess Community Hospital	Washington	Daviess
St. Vincent Clay Hospital	Brazil	Clay
Johnson Memorial Hospital	Franklin	Johnson
Memorial Hospital & Health Care Center	Jasper	Dubois
Deaconess Hospital	Evansville	Vanderburgh
Perry County Memorial Hospital	Tell City	Perry
Woodlawn Hospital	Rochester	Fulton

Indiana colleges and universities have also expanded their tobacco use policies on campuses in 2006. Coming August 2006, Indiana University Purdue University at Indianapolis, Indiana University and Purdue University at Columbus, and Indiana University at Richmond will make their campus grounds smoke free. For IUPUI, this announcement is the first major medical center/urban campus to pass such a policy. In May 2006, the University of Indianapolis made its grounds tobacco free. Ivy Tech campuses system-wide have also gone smoke free. This stance against tobacco use shows concern for students and staff, as well as prepares students for a workplace with a tobacco free policy. Additional policy information can be found in the ITPC coalition pages beginning on page 115.

Local tobacco control coalitions across Indiana are working to increase youth protections from secondhand smoke. While federal law prohibits smoking within school buildings, local jurisdictions have enacted policies that are more restrictive and encompass all school grounds. Coalitions are working with school districts to ensure tobacco use is not allowed on school campuses anywhere. Progress is being made with schools throughout Indiana as 27 counties have all tobacco free schools districts providing approximately 50 percent of our youth with protection from secondhand smoke at school. Another 36 counties have a portion of their school districts with tobacco free campuses. However, the remaining 29 counties do not have a tobacco free campus at any of the school districts in their counties. Four school districts in SFY 2006, received the Gary Sandifur Tobacco

Free School Award for having a 100% tobacco free campus. These include: Southwest Parke Community Schools; Cloverdale Community School Corporation; Greater Clark County School Corporation; and Turning Point Education Center (Greene County). More on how Indiana youth are leading the initiative to get tobacco off of their campuses can be found in the **Community Program** section.

Figure 4: Tobacco Free School Map 2006

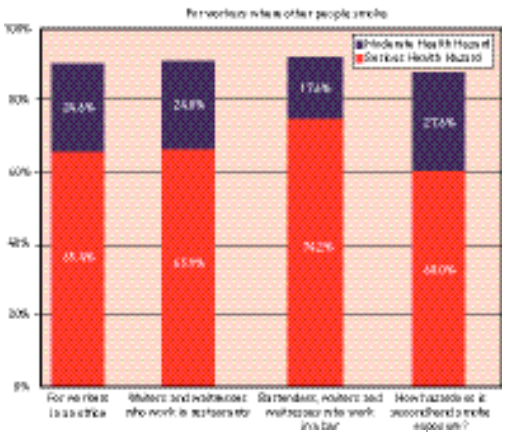


Many Hoosiers spend a significant part of their day at the workplace. The 2004 Indiana Adult Tobacco Survey indicates that 72 percent of adults' indoor work policy prohibits smoking in all work areas. Similarly, of the largest employees from each county in Indiana, 87 percent have completely smoke free indoor work areas. This is an increase from data in 2003 of the top five largest employees from each county in Indiana, 68 percent have completely smoke free indoor work areas. However, very few (13%) of these large employers have smoke free grounds and buildings. There has been no change on this since 2003[126]. Although there has been a relative increase in the proportion of total indoor workforce working under a smoke-free policy in Indiana, compared to the rest of the U.S. The Midwestern states overall are trailing the rest of the country in their worksite policies[127]. From a sample of top minority employers in 21 counties, 85 out of 119 businesses were smoke free indoors, with only 5 of those 85 also with a smoke free grounds policy[128].

Support for smoke free workplaces and knowledge of secondhand smoke dangers are high. Seven out of ten Hoosier adults support smoke free workplaces, including restaurants and bars. Most adults are very (47%) or somewhat (32%) concerned about the health effects of secondhand smoke. Slightly over half of Hoosier adults believe that secondhand smoke is very harmful. Similarly, many expressed knowledge that exposure to secondhand smoke causes various health problems. These data, however, show strong differences between attitudes and beliefs of current smokers compared to other respondents. Current smokers were much less likely than nonsmokers to be aware of each of the dangers of secondhand smoke.

Six of ten adults think exposure to secondhand smoke is a serious health hazard. Nearly 90% feel that workers of various occupations who are exposed to smoke in the workplace are experiencing a serious to moderate health hazard. A greater proportion of African Americans (76%) and Latinos (75%) say that secondhand smoke exposure is a serious health hazard compared to Whites (60%).

Chart 33: Health Hazard Beliefs about Secondhand Smoke



Beliefs of tobacco's harmful effects impact a smoker's intention to quit smoking. Those smokers who are aware that smoke from other people's cigarettes is very harmful were more

than twice as likely to intend to quit smoking or attempt to quit, and more than three times as likely to quit smoking successfully, compared to smokers without this knowledge .

- Attitudes toward smoke free policies in Indiana's minority communities show that African Americans were more likely to believe that secondhand smoke is very harmful to one's health compared to members of other communities.
- Latinos are more likely to agree that second hand smoke is a cause of health problems.
- African Americans nonsmokers are more likely than Whites to be exposed to second hand smoke in homes and cars.
- Whites (66%) and Latinos (77%) are more likely to have smoke free homes than African Americans (48%).
- Of indoor adult workers, all race/ethnic groups are equally protected by worksite policies with approximately seven out of ten workers protected.
- 18-24 year old nonsmokers are the most exposed to secondhand smoke in homes compared to other age groups.
- While not statistically significant the proportion of 18-24 year olds working indoors are the least protected workers.
- Women (80%) indoor workers are more likely to be covered by a smoke free worksite policy than male workers (64%).

Funding for Comprehensive Tobacco Control Programs

Adequate funding is necessary to carry out a comprehensive tobacco control program and to improve on Hoosier's health that is impacted by the State's alarming tobacco use rates. In 2002, the American Lung Association, American Cancer Society, American Heart Association and Campaign for Tobacco-Free Kids praised Indiana's leaders for allocating $32.5 million a year of the state's tobacco settlement money to fund a tobacco prevention program. At the time, Indiana ranked sixth in the nation in funding tobacco prevention and was spending 93 percent of the minimum amount of $34.8 million that the U.S. Centers for Disease Control and Prevention (CDC) has recommended the state spend on tobacco prevention. Indiana was one of only four states – along with Maine, Maryland and New Jersey – praised in the report.

However, this strong funding level for Indiana's comprehensive tobacco control program was reduced by approximately 70 percent for the State Fiscal Years 2004 and 2005. The appropriation was cut to $10.8 million annually. As a result, the ITPC Executive Board placed budget cuts in components of the program. Indiana now funds tobacco prevention at 69 percent below the minimum amount recommended by the CDC. In contrast, the tobacco companies have increased their marketing expenditures in Indiana to a record $475 million a year, amounting to 44 times what the state currently spends on programs to prevent kids from smoking and help smokers quit.

Data described early in this report shows that Indiana's adult smoking rate increased from 24.9 percent in 2004 to 27.3 percent in 2005. While this change is not statistically significant, it represents a troubling reversal from recent years as Indiana's adult smoking rate declined from 27.7 percent in 2002 to 24.9 percent in 2004. This reversal of progress follows cuts to funding. Adult smoking rates in Indiana declined by more than 10 percent between 2002 and 2004, but declines reversed after funding was cut in SFY 2004 and subsequent years.

The good news for Indiana is that ITPC remains a strong, well-run program despite the budget cuts and is poised to deliver dramatic progress if its budget is restored to the CDC minimum of $34.8 million a year. Indiana also has adequate tobacco-generated revenue to do the job right. In SFY 2006, the state will collect a record $458 million from the tobacco settlement and tobacco taxes, that funding a tobacco prevention program at CDC minimum levels would require less than eight percent of Indiana's total tobacco revenue.

In addition, Indiana and the several other states will receive bonus payments beginning in 2008, under the terms of the 1998 state tobacco settlement. The MSA payments will bring Indiana an additional $23.5 million a year in settlement money, giving state leaders a second chance to keep the promise of the settlement

and properly fund tobacco prevention. By allocating these new, windfall MSA payment increases to expand their tobacco prevention efforts, Indiana could begin to reduce smoking-caused suffering, disease, and death more effectively. Such new state investments in tobacco prevention would also improve the state's economic health by improving worker productivity and sharply reducing public and private smoking-caused costs in the state.

Other states that have implemented these three measures of 1) adequate tobacco control funding, 2) higher tobacco taxes, and 3) strong local smoke free laws; have reported dramatic smoking declines that far surpass national trends. Maine, which has one of the nation's oldest and best-funded tobacco prevention programs, a high cigarette tax and a statewide smoke-free law, reduced smoking by 64 percent among middle school students and by 59 percent among high school students between 1997 (when it launched its program) and 2005. Washington State has also implemented all three measures and reduced adult smoking from 22.4 percent in 1999 to 19.5 percent in 2004. Washington reduced youth smoking by 57 percent among sixth graders, by 49 percent among eighth graders, by 48 percent among tenth graders and by 44 percent among twelfth graders between the late 1990s and 2004.

Providing Cessation Coverage through Health Plans and Programs

The cost and lack of access to cessation treatment is one of the primary obstacles to reducing smoking in the United States. Improved access to smoking cessation services is one of the keys to accelerating the decline in adult smoking rates. More than 80 percent of Hoosier smokers want to quit, however, few will succeed without help[130]. Treating tobacco use doubles the rate of those who successfully quit[131]. Tobacco-use cessation treatments that include counseling and medications, or a combination of both are recommended. Health insurance coverage of medication and counseling increase the use of effective treatments[132]. Providing cessation services to employees through onsite employee assistance programs or through health plans can save businesses money. Indiana covers the cost of cessation therapy and counseling as a part of the state's Medicaid benefits; however, this service has been underutilized.

The use of tobacco quitlines is a strongly recommended evidence-based strategy recommended by the Guide to Community Health Services for Tobacco Control. In March 2006, the Indiana Tobacco Quitline was established under the direction of Smokefree Indiana. Hoosiers are using this highly effective cessation service as 3,500 individuals called the Quitline during the pilot phase from March 22 to June 29, 2006. More information about Indiana's Tobacco Quitline can be found on page 86.

We do not know what percentage of Indiana's employers provides cessation therapy and counseling as a part of their employee benefit package, although that number seems to be inadequate. Of Indiana's large employers approximately 36 percent provide cessation through their worksite while fewer offer benefits through employer-provided health plans (27%). This is a nominal increase since 2003.

In 2004, only 17.6 percent of Indiana smokers were aware that their insurance plan covers cessation services. Twenty-three percent (22.7%) indicate that their coverage does not pay for cessation services. One-third (32.4%) of Indiana adult smokers are not aware whether or not their health insurance covers cessation assistance.

Of a sample of Indiana's large minority employers, only 13 out of 119 employers (11% of the sample) provided cessation through employer-provided health plans and fewer (8 out of 119) offered cessation as a benefit through a health insurance plan[133].

In 2004, more Hoosier smokers reported availability of smoking cessation help at their workplace and coverage of smoking cessation services by their health insurance. It is not clear from these data whether these increases are due to more employees offering cessation help, more health insurance policies covering smoking cessation or smokers becoming more

aware of these resources. The 2004 results show that more smokers have tried to use nicotine replacement therapies in order to quit smoking than did in 2002. Since the use of nicotine replacement therapies involves substantial out-of-pocket costs to smokers, this trend suggests that Hoosier smokers are becoming more committed to quitting.

Local coalitions working in Indiana's 92 counties, have the resources in place to work with any Indiana business looking to encourage tobacco cessation. Partnerships such as these can serve as ways to improve overall health and bring cost savings to businesses and the State.

Finally, legislation in 2006, (H.E.A.1420) was passed allowing employers in Indiana to charge employees who smokemore for their health insurance and offer incentives to nonsmoking employees.

See **Economic Impact of Tobacco Use** beginning on page 24.

Authorizing the FDA to Regulate All Tobacco Products

Since the U.S. Surgeon General, Luther Terry released the first Surgeon General's Report linking cigarettes to lung cancer in 1964, government actions were taken to protect the public. Through warning labels on packs of cigarettes, to recent advertising and marketing restrictions through MSA in the late 1990s, and then the addition of local and state policies protecting people from secondhand smoke. However there has been no policy to regulate the product itself. No federal government agency has the authority to regulate tobacco products.

In May 2004, identical, bipartisan bills were introduced in the U.S. Senate and House of Representatives to grant the U.S. Food and Drug Administration authority to regulate tobacco products. This marks the first time that identical bills supported by the public health community have been introduced in both houses of Congress. However, it failed to pass.

Although on March 17, 2005, U.S. Senators Mike DeWine (R-OH) and Edward Kennedy (D-MA) and U.S. Representatives Tom Davis (R-VA) and Henry Waxman (D-CA) introduced identical, bipartisan bills in Congress to grant the U.S. Food and Drug Administration (FDA) authority to regulate tobacco products. Public health organizations, including the American Cancer Society, American Heart Association, American Lung Association and Campaign for Tobacco-Free Kids, worked closely with these Members of Congress to draft this legislation and have enthusiastically endorsed it. These groups feel these are the strongest, most bipartisan and most comprehensive bills ever introduced to grant the FDA authority over tobacco products.

Overall, this legislation would significantly change every aspect of the manufacturing, marketing, labeling, distribution and sale of tobacco products. These measures can significantly reduce the number of people who start to smoke, significantly increase the number of smokers who quit and reduce harm to those who are unable to quit. The result will be to greatly reduce the number of people who use tobacco products and become sick and die as a result.

These bills would protect kids and save lives by granting the FDA authority to[134]:

- Restrict tobacco advertising and promotions, especially to children
- Stop illegal sales of tobacco products to children
- Require disclosure of the contents of tobacco products and tobacco industry research about the health effects of their products
- Require changes in tobacco products, such as the reduction of elimination of harmful chemicals, to make them less harmful or less addictive
- Prohibit health claims about so-called "reduced risk" products that are not scientifically proven or that would discourage current tobacco users from quitting or encourage new users to start
- Require larger and more informative health warnings on tobacco products

This legislation would bring changes to every aspect of the manufacturing, marketing, labeling, distribution and sale of tobacco products. These measures can significantly reduce the number of people who start smoking, increase the number of smokers who quit, and reduce harm to those who are unable to quit. Granting FDA regulation of tobacco products is intended as a complement, for other tobacco prevention, cessation and control measures.

The need for regulation of tobacco products can be demonstrated here in Indiana. The introduction of new tobacco products in the market has had a direct impact on Indiana in recent years. In 2001, Brown&Williamson (B&W) used Indianapolis and surrounding central Indiana as a test market for Advance™. In 2002, Ariva® (B&W) arrived in stores, followed by Quest® (Vector Tobacco) in 2003, as Indiana was one of seven states testing this new line of products. Research shows that smokers have misconceptions about the health risks of so-called "light" and "ultra-light" cigarettes[135]. Successful marketing of the tobacco companies foster these beliefs. Scientific studies indicate that these products have not resulted in different rates of tobacco-related deaths and diseases compared to those who smoke "regular" cigarettes. Smoking cigarettes that have a lower yield of tar does not substantially reduce the risk for lung cancer[137].

Tobacco companies continue these deceptive marketing practices as they introduce new products continuing to appeal to the health concerns of smokers. Indianapolis is once again being targeted by the tobacco industry in 2006 with Taboka, a smokeless, spitless product from Philip Morris.

Data from the 2004 Indiana Adult Tobacco Survey (IATS), illustrate that these misconceptions are present among Hoosier smokers and the need for FDA authority to regulate all tobacco products.

- Twenty percent (20%) of all Hoosiers have heard of Quest with 20% of those who have heard of it have tried it; nearly 43% of smokers have heard of Quest.
- Twelve percent (12%) of all Hoosiers have heard of Advance with 12% of those who have heard of it have tried it. Approximately 18% of smokers are aware of Advance.
- One-fifth (18%) of Hoosier agreed that smoking these new kinds of tobacco products is safer than smoking regular cigarettes.

Ensuring Strong Youth Access Laws and Enforcing Those Laws

Indiana code (I.C. 35-46-1-10) prohibits selling tobacco products to juveniles. While early data indicates that over the last year, compliance to the law has improved, the methodology for penalties is considerably weaker than other states. States that have seen the greatest improvement in enforcement of youth access laws require that a license be obtained to sell tobacco products and that progressive penalties for retailers who sell tobacco to juveniles includes eventual revocation of license.

I.C. 7.1-3-18.5 requires all tobacco retailers to have a certificate to sell tobacco products. Selling without a certificate is a class A infraction (up to a $10,000 fine). This law also allows the Alcohol Tobacco Commission (ATC) to handle all tobacco fines. Civil penalties collected for tobacco violations are deposited in the youth tobacco education and enforcement fund. It also repeals prohibition on certain tobacco billboard advertisements and repeals a provision concerning advertising of tobacco products that is preempted by federal law.

Another law, I.C. 24-3-5, requires a merchant who sells cigarettes to a person in Indiana through direct mail or the Internet to: (1) ensure that the customer is at least 18 years of age; and (2) pay the state cigarette tax or provide notice that the customer is responsible for the unpaid state taxes on the cigarettes. It also establishes penalties for violations. This legislation also requires the merchant to furnish the Indiana Department of Revenue the names, addresses and date of birth of those who purchase cigarettes through direct mail or Internet in order to collect excise taxes and use taxes. This also includes the sale of all tobacco products via the Internet, direct mail, and telephone.

Local jurisdictions in Indiana are preempted from passing laws stronger than Indiana's state youth access laws. As a result, continued improvement in the state law and enforcement are the only avenues to improve this policy area.

Reducing Tobacco Advertising, Promotion, and Marketing

The Federal Trade Commission's (FTC) most recent annual report on cigarette sales and advertising for 2003 shows that cigarette manufacturers spent a record $15.4 billion on advertising and promotion for that year, an increase of 21 percent from the $12.7 billion spent in 2002. Over $475 million was spent in Indiana. That is the largest amount reported since the FTC began tracking cigarette sales and advertising in 1970. The tobacco industry spends more than $1 million a day to advertise and promote its deadly products in Indiana. Tobacco advertising increased 123% since the tobacco companies agreed to curtail some aspects of their marketing as part of the November 1998 legal settlement with the states.

The tobacco companies' spending for marketing in a single day in the U.S. ($41 million) represents more than the CDC recommended minimum spending level for Indiana, and is nearly four times Indiana's current annual budget for tobacco prevention.

The bulk of the enormous increase in advertising and promotional spending by the tobacco industry is in the area of promotional allowances and retail value added, accounting for 71% ($10.8 billion) of total spending. This money is being spent for retail promotions and product placements that heavily impact children and teenagers. Two-for-one offers and other enticements are particularly effective with teenagers and children who have less disposable income than adults and are more likely to be influenced by promotional items in convenience stores. More than $1.3 billion was spent on price discounts paid to cigarette retailers and promotions involving free cigarettes.

The tobacco industry continues to push the envelope with its marketing tactics. Recent tactics come from Brown & Williamson Tobacco Company (B&W) and the promotion of their Kool cigarettes. The B& W promotion used a hip-hop theme to promote Kool cigarettes, and included special packs called Kool Mixx packs. These packs featured images of juvenile-oriented disc jockeys, hip-hop artists and dancers that display a "mural" as the two packs are placed next to each other. These special packs sell for the same price as other Kool products. Buyers of two packs received a free "stick radio," a tiny radio with ear plugs. This Kool Mixx pack promotion was paired with a national disc-jockey competition, with the slogan "Soundtrack to the Streets." The pairing of these deadly tobacco products with the hip-hop culture is clearly a way to promote smoking to youth. It is widely known that young people listen to this type of music and can be enticed through such music products as cds and radios. This marketing

violates the MSA in that it is clearly using tactics and marketing techniques to reach youth through the sponsorship of this DJ competition and giveaways. In May 2004, Indiana's Attorney General joined with 30 other state's attorneys general signing onto a letter from the New York Attorney General planning to file suit against B&W for violating the MSA. B&W stopped the promotion.

Store displays target youth. Research shows that 75 percent of teens visit a convenience store at least once a week[138]. Indiana current (55%) and frequent (100%) middle school youth smokers were more likely to purchase or receive items with a tobacco company logo than youth who never smoked (17%). Similarly for high school youth, current (44%) and frequent (48%) smokers were more likely to purchase or receive items with a tobacco company logo than youth who never smoked (10%)[139]. Youth who are more likely to wear such items encourages smoking behavior and a positive attitude toward tobacco companies.

Market research shows that African Americans prefer menthol cigarettes. Indiana data support this finding. More than half (63%) of African American high school smokers in Indiana smoke menthol cigarettes[139]. Research also shows that youth and African Americans like flavor cigarettes. In Indiana, approximately four out of ten youth smokers smoke menthols[139]. This preference for flavored cigarettes coupled with the marketing through the "hip hop" culture, clearly indicates B&W was targeting youth.

Kool also introduced a series of flavored cigarettes in special packs, marketed under the name "Smooth Fusions". The flavors include "Midnight Berry", "Caribbean Chill", "Mintrigue", and "Mocha Taboo". This use of these flavors is further evidence the company is targeting youth, especially black youth.

R.J. Reynolds - the same company that once marketed cigarettes to kids with a cartoon character, Joe Camel - launched a series of flavored cigarettes, including a pineapple and coconut-flavored cigarette called "Kauai Kolada" and a citrus-flavored cigarette called "Twista Lime." In November 2004, they introduced Camel "Winter Blends" in flavors including "Winter Warm Toffee" and "Winter MochaMint". Established smokers are unlikely to give up their favorite brands for these new cigarettes, but kids will be tempted to give them a try and many will get hooked. Finally, the U.S. Smokeless Tobacco Company has gotten in the game with marketing spit tobacco with flavors including berry blend, mint, wintergreen, apple blend, vanilla and cherry.

Bills introduced in Congress that would give the Food and Drug Administration the power to regulate tobacco products also would ban the sale of candy-flavored cigarettes. Bills to ban sales of flavored cigarettes also have been introduced in a few states.

Fire Safe Cigarettes

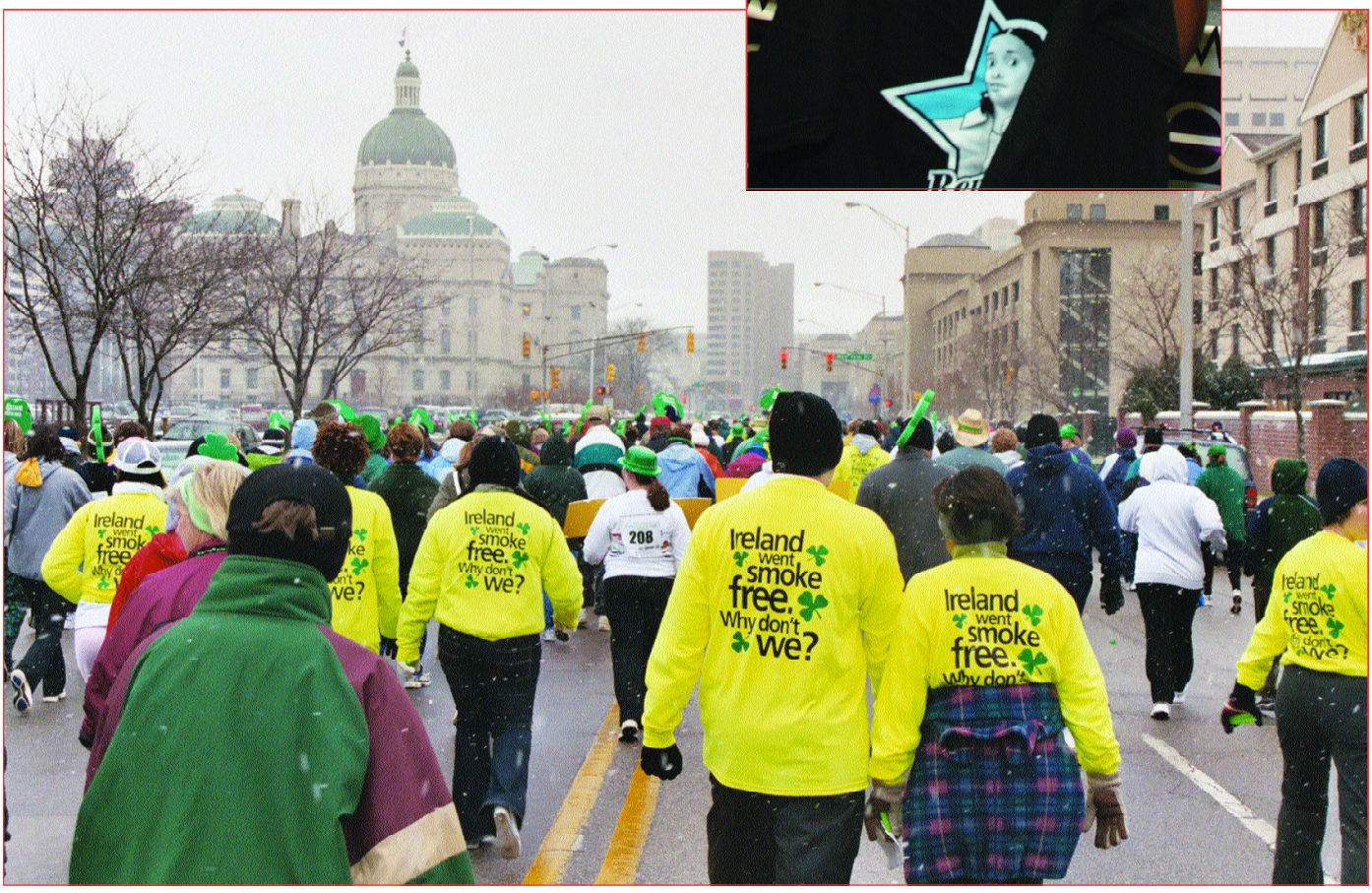
Smoking fires are the nation's number one cause of fire death, annually responsible for 500 deaths and 1,300 injuries, as well as $371 million in residential property damage[140]. Many of these fire injuries and deaths occur in innocent children and adults who do not smoke. In addition to lost lives these fires cause $4 billion in property damage[141].

While it is not possible to ensure every smoker uses care when handling an intentionally burned product, it is possible to alter the way that product is manufactured to make cigarette-caused fires far less likely. In June 2004, New York became the first state to require new "fire-safe" cigarettes to be sold. The law required tobacco manufacturers to produce cigarettes meeting new fire safety standards. These standards came out of a technical study group mandated by the federal Safe Cigarette Act of 1984 and were deemed "technologically and economically feasible." This law is meant to cut down on the number of smoking-related fires.

The new cigarettes are wrapped in special ultra-thin banded paper that essentially inhibits burning. It is important to note that the lower- ignition paper does nothing to curtail the toxicity of cigarettes or reduce the health effects of smoking.

Major cigarette makers have been urged to use New York's standards to produce and distribute fire-safe cigarettes to other states. Unfortunately, Hoosiers are not protected by a similar regulation.

Five additional states have passed such legislation including Vermont, Illinois, California, New Hampshire, and Massachusetts (July 2006).



TOBACCO MASTER SETTLEMENT AGREEMENT ACCOUNT

As of June 30, 2006

Total Settlement Receipts	$969,667,789.00
Total Interest Earnings (since inception)	$13,812,060.00
Total Revenue	**$983,479,849.00**
Less Transfers Out	$889,491,618.00
Total Expenses	**$889,491,618.00**
Account Balance	**$93,988,231.00**

Pursuant to IC 4-12-1-14.3 all payments made by the tobacco industry to the State of Indiana in accordance with the Master Settlement Agreement are deposited in the Indiana Tobacco Master Settlement Agreement fund. Money may be expended, transferred, or distributed from the fund if authorized by law.

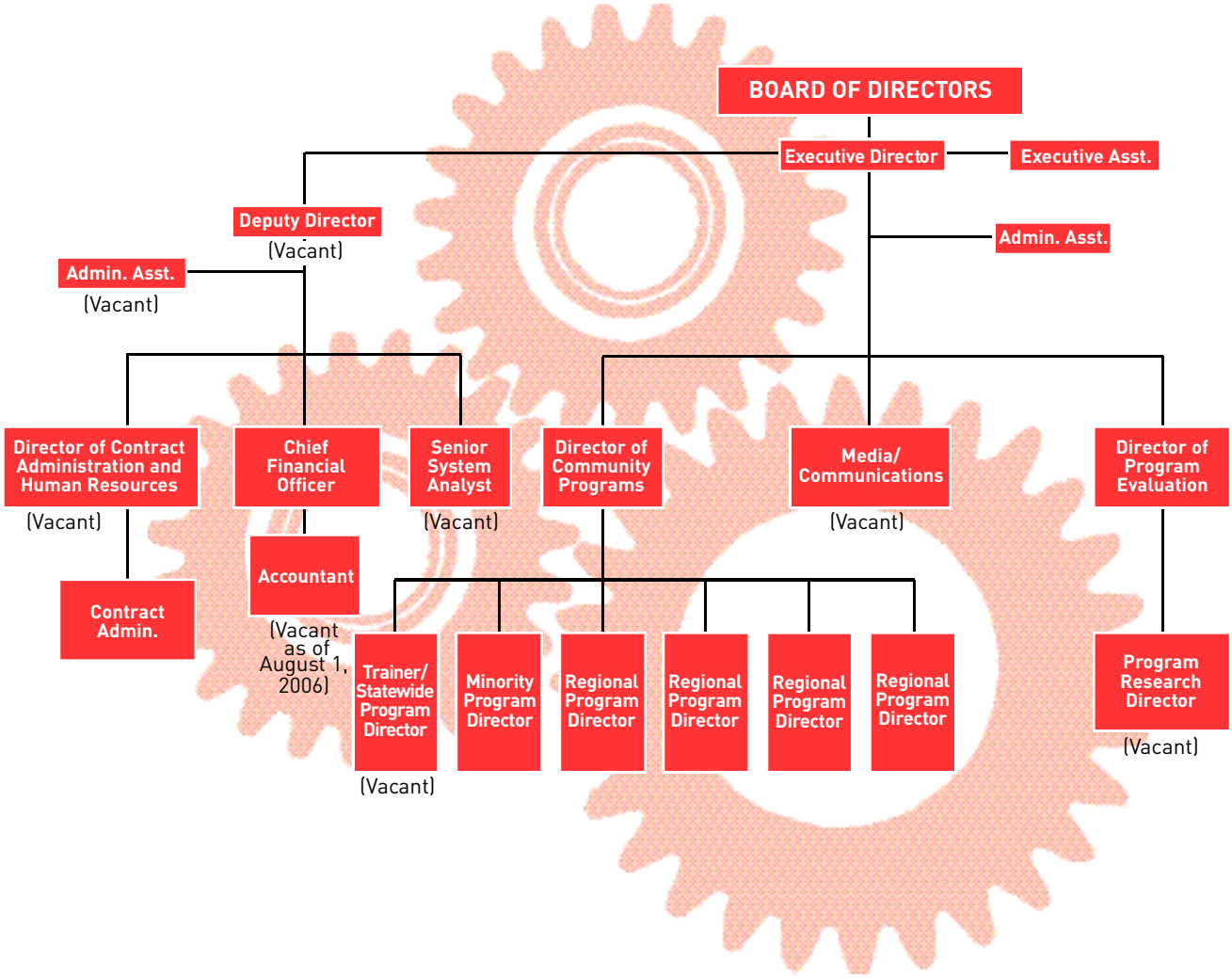
TOBACCO MASTER SETTLEMENT ACCOUNT EXPENDITURES

	(in millions)	Actual FY00	Actual FY01	Actual FY02	Actual FY03	carry over	Actual FY04	carry over	Actual FY05	carry over	Actual FY06	carry over	Appropriation FY07	Estimate 7% FY07
	Beginning Balance	$-	$77.40	$113.20	$90.50		$275.90		$238.10		$192.70		$126.40	$127.50
	Settlement Payments	$167.00	$127.80	$149.20	$148.00		$126.80		$130.00		$117.90		$132.60	$132.60
	Other Revenue	$-	$-	$-	$-		$3.10		$-		$3.20		$-	$-
	Prior Period Adjustment										$23.40			
	Transferred to Savings	$73.70	$53.40	$59.70	$59.20		$-		$-		$-		$-	$-
	Transfer to General Fund			$29.70	$30.30		$-		$-		$-		$-	$-
	Spending:													
Department of Health	ISDH Breast Cancer	$-	$-	$-	$-	$-	$0.10	$-	$0.10	$-	$0.10	$-	$0.10	$0.10
	ISDH Prostate Cancer	$-	$-	$-	$-	$-	$0.10	$-	$0.10	$-	$0.10	$-	$0.10	$0.10
	ISDH Sickle Cell	$-	$-	$-	$-	$-	$0.20	$-	$0.20	$-	$0.20	$-	$0.20	$0.20
	ISDH Operating account	$-	$-	$-	$-	$-	$25.70	$-	$25.70	$-	$24.40	$-	$27.30	$25.40
	ISDH Cancer Registry	$-	$-	$-	$-	$-	$0.20	$-	$0.20	$-	$0.20	$-	$0.30	$0.20
	ISDH Minority Health Initiative	$-	$-	$-	$-	$-	$2.10	$-	$2.10	$-	$1.90	$-	$2.10	$1.90
	ISDH HIV/AIDS Services	$-	$-	$-	$-	$-	$2.30	$-	$2.30	$-	$2.00	$-	$2.30	$2.20
	ISDH Drug Afflicted Babies	$-	$-	$-	$-	$-	$0.10	$-	$0.10	$-	$0.10	$-	$0.10	$0.10
	ISDH AIDS Education	$-	$-	$-	$-	$-	$0.70	$-	$0.70	$-	$0.60	$-	$0.70	$0.70
	ISDH Chronic Disease	$-	$-	$-	$-	$-	$0.50	$-	$0.50	$-	$0.50	$-	$0.50	$0.50
	ISDH WIC Supplement	$-	$-	$-	$-	$-	$0.20	$-	$0.20	$-	$0.10	$-	$0.20	$0.20
	ISDH MCH Supplement	$-	$-	$-	$-	$-	$0.20	$-	$0.20	$-	$0.20	$-	$0.20	$0.20
	ISDH Aid to TB Hospitals	$-	$-	$-	$-	$-	$0.10	$-	$0.10	$-	$0.10	$-	$0.10	$0.10
	Newborn Screening	$-	$-	$0.50	$0.50	$-	$-	$-	$-	$-	$-	$-	$-	$-
	ISDH Local Health Maintenance Fund	$-	$1.50	$1.30	$1.40	$-	$3.90	$-	$3.90	$-	$3.60	$-	$3.90	$3.60
	Local Health Dept. Trust Account	$-	$-	$3.00	$3.00	$-	$3.00	$-	$3.00	$-	$2.80	$-	$3.00	$2.80
	Community Health Centers	$-	$12.20	$16.20	$13.90	$4.70	$18.30	$-	$10.90	$-	$11.80	$-	$15.00	$14.00
	Community Health Centers Capital	$-	$0.80	$6.30	$2.40	$0.50	$0.50	$0.00	$0.10	$0.00	$-	$0.00	$-	$-
	Tobacco Health Programs	$-	$-	$-	$2.40	$2.40	$1.10	$1.30	$1.00	$0.30	$0.70	$-	$2.50	$2.30
	Prenatal Substance Abuse	$-	$-	$-	$0.30	$0.10	$0.30	$0.00	$0.20	$0.00	$0.10	$-	$0.20	$0.10
	Minority Epidemiology	$-	$-	$-	$-	$-	$0.50	$-	$0.50	$-	$0.50	$-	$0.50	$0.50
FSSA	Children's Health Insurance Program - Assist.	$18.80	$28.10	$21.10	$33.60	$-	$23.80	$-	$16.00	$-	$27.20	$-	$33.80	$22.70
	Children's Health Insurance Program - Admin.								$0.70	$-	($4.60)	$-		$0.90
	Prescription Drug Account/Hoosier Rx	$-	$4.40	$4.70	$6.50	$14.60	$8.80	$13.80	$13.80	$8.40	$4.30	$11.70	$8.00	$7.40
	Developmentally Disabled Client Services	$-	$-	$13.40	$30.30	$-	$21.30	$-	$15.30	$-	$-	$-	$24.40	$-
	Residential Services for Developmentally										$22.30	$-		$22.30
	Residential Services (Case Management)								$2.00	$-	$1.60	$-		$1.60
	Home Health Provider Salary								$3.00	$-	$-	$-		$-
	Social Services Block Grant								$4.00	$-	$-	$-		$-
	DDARS Admin.	$-	$-	$0.50	$-	$-	$3.00	$-	$3.00	$-	$3.00	$-	$3.00	$3.00
	Community Mental Health Centers	$-	$-	$-	$-		$-	$-	$-	$-	$1.90	$-	$2.00	$1.90
Econ Development	Value Added Research Fund	$-	$-	$-	$-	$-	$0.60	$-	$0.60	$-	$0.60	$-	$0.60	$0.60
	Rural Development Administration Fund	$-	$-	$-	$-	$-	$-	$2.40	$1.20	$3.60	$1.80	$4.00	$2.40	$2.40
	Rural Development Council Fund	$-	$-	$-	$-	$-	$-	$1.20	$1.20	$1.30	$0.80	$1.60	$1.20	$1.20
	Technology Development Grant Fund	$-	$-	$-	$-	$-	$-	$4.50	$4.30	$4.70	$0.50	$8.30	$4.50	$4.50
	21st Century Research & Technology Fund	$-	$-	$-	$-	$-	$-	$-	$-	$-	$-	$-	$-	$-
	21st Century Research & Technology Fund	$-	$-	$-	$-		$37.50	$-	$37.50	$-	$34.90	$-	$37.50	$37.50
	Tobacco Farmers & Rural Community Impact	$-	$-	$0.30	$0.04	$-	$0.10	$-	$-	$-	$-		$-	$-
	Independent Living Assistance - DCS	$-	$-	$-	$-		$-	$-	$-	$-	$-	$0.90	$1.00	$0.90
	Attorney General's Office	$-	$-	$-	$-		$-	$-	$-	$-	$0.30	$-	$0.30	$0.30
	Tobacco Use Prevention & Cessation (ITPC)	$-	$0.20	$19.20	$22.80	$14.20	$16.90	$8.10	$15.10	$3.80	$10.00	$2.50	$10.90	$10.10
	Commission on Hispanic & Latino Affairs	$-	$-	$-	$-	$-	$-	$0.10	$0.10	$0.10	$0.20	$0.10	$0.10	$0.10
	Health Care Advisory Board	$-	$-	$1.70	$-	$-	$-	$-	$-	$-	$-		$-	$-
	Regional Health Care Construction	$-	$-	$0.20	$0.80	$-	$2.40	$15.10	$1.90	$14.60	$7.30	$15.50	$10.60	$10.60
	Total Spending	**$18.80**	**$47.20**	**$88.40**	**$118.00**	**$36.50**	**$174.50**	**$46.50**	**$171.60**	**$36.90**	**$162.10**	**$44.70**	**$199.40**	**$183.00**
	ITPC Interest Earned				$0.02		$1.10		$0.20		$0.20			
	Interest Earned	$2.90	$8.70	$5.90	$0.18		$0.30		$0.10		$0.10			
	Encumbrances						$5.40		$4.10		$3.10			
	Adjustment due to rounding									($0.10)		$-		
	Balance Available for Spending	**$77.40**	**$113.20**	**$90.50**	**$31.20**		**$238.10**		**$192.70**		**$172.30**		**$59.60**	**$77.10**
	Savings Transfer	$73.70	$53.40	$59.70	$59.20		$-	$-	$-		$-		$-	
	Percent Saved	50%	50%	40%	40%				0%					
	Savings Balance	$73.70	$127.10	$186.80	$246.00		$-		$-		$-		$-	$-
	adjustment				($1.30)	$223.30	$-							
	Undesignated Fund Balance											$1.10		
	Fund Balance	**$151.10**	**$240.30**	**$277.30**	**$275.90**	**$259.80**	**$238.10**		**$192.70**		**$171.20**		**$59.60**	**$77.10**

ITPC Staff

Karla S. Sneegas	Executive Director
Celesta Bates	Chief Financial Officer
Anita Gaillard	Director of Community Programs
Miranda Spitznagle	Director of Program Evaluation
Becky Haywood	Executive Administrative Assistant
Jack Arnett	Regional Program Director – Northern Indiana
Karen O'Brien	Regional Program Director – Southwestern Indiana
Dan Morgan	Regional Program Director – Southeastern Indiana
Jamie Broderick	Regional Program Director – Central Indiana
Craig Wesley	Regional Program Director – Minority Programs
Kristen Kearns	Contracts Administrator
Kelley Rose	Accountant
Barbara Cole	Administrative Assistant

Indiana Tobacco Prevention and Cessation Agency Organizational Chart



Executive Board Structure

The Tobacco Use Prevention and Cessation Executive Board (Tobacco Board) was established by Indiana Code 4-12-4-4. This stipulates the following Board structure:

Five (5) ex officio members:

- The Executive Director (nonvoting member)
- The State Superintendent of Public Instruction
- The Attorney General
- The Commissioner of the State Department of Health
- The Secretary of the Family and Social Services Administration

Eleven (11) members appointed by the governor who possess:

- Knowledge, skill, and experience in smoking reduction and cessation programs, health care services, or preventive health measures

Six (6) members who are appointed by the governor representing the following organizations:

- The American Cancer Society
- The American Heart Association, Indiana Affiliate
- The American Lung Association of Indiana
- The Indiana Hospital and Health Association
- The Indiana State Medical Association
- The Indiana Council of Community Mental Health Centers

The Governor shall designate a member to serve as chairperson. The executive board shall annually elect one of its ex-officio members as vice chairperson. IC 4-12-4-4(i).

Executive Board Members

Karla S. Sneegas . . . . . Indianapolis
David Austin, D.D.S. . . . . . Indianapolis
Danielle Patterson . . . . . Indianapolis
Victoria Champion, Ph.D. . . . . . Indianapolis
Richard Feldman, M.D. . . . . . Indianapolis
Patricia Hart . . . . . Muncie
Stephen Jay, M.D. . . . . . Indianapolis
James Jones . . . . . Cicero
Robert Keen, Ph.D. . . . . . Greenfield
J. Michael Meyer . . . . . Borden
Pat Rios . . . . . Indianapolis
Steve Simpson, M.D. . . . . . Gary
Alan Snell, M.D. . . . . . South Bend
Mohammad Torabi, Ph.D. . . . . . Bloomington
Nancy Turner . . . . . Indianapolis

Ex Officio Members

Judith Monroe, M.D. . . . . . State Health Commissioner
Stephen Carter . . . . . Attorney General
Suellen Reed, Ed.D. . . . . . State Superintendent of Public Instruction
E. Mitch Roob . . . . . Secretary Family and Social Services Administration

Advisory Board Structure

Advisory Board (IC 4-12-4-16)

ITPC has an advisory board that meets quarterly and serves to offer recommendations to the Executive Board on the following:

- Development and implementation of the mission and long range plan;
- Criteria to be used for the evaluation of grant applications;
- Coordination of public and private efforts concerning reduction and prevention of tobacco usage; and
- Other matters for which the Executive Board requests recommendations from the advisory board.

Advisory Board Members

Robert Arnold . . . . . Wolcotteville

Arden Christen, D.D.S. . . . . . Indianapolis

Diane Clements . . . . . Evansville

Bennett Desadier, M.D. . . . . . Indianapolis

Steve Guthrie . . . . . Anderson

Kiki Luu . . . . . Fort Wayne

Heather McCarthy . . . . . Griffith

Nadine McDowell . . . . . Gary

Steve Montgomery, D.C.P. . . . . . Franklin

Diana Swanson, N.P. . . . . . Bloomington

Olga Villa Parra . . . . . Indianapolis

Cecilia Williams . . . . . Muncie

Executive Board Vision and Mission Statement

Our Vision

The Tobacco Use Prevention and Cessation Trust Fund Executive Board's vision is to significantly improve the health of Hoosiers and to reduce the disease and economic burden that tobacco use places on Hoosiers of all ages.

Our Mission

The Tobacco Use Prevention and Cessation Trust Fund exists to prevent and reduce the use of all tobacco products in Indiana and to protect citizens from exposure to tobacco smoke. The Board coordinates and allocates resources from the Trust Fund to:

- Change the cultural perception and social acceptability of tobacco use in Indiana
- Prevent initiation of tobacco use by Indiana youth
- Assist tobacco users in cessation
- Assist in reduction and protection from secondhand smoke
- Support the enforcement of tobacco laws concerning the sale of tobacco to youth and use of tobacco by youth
- Eliminate minority health disparities related to tobacco use and emphasize prevention and reduction of tobacco use by minorities, pregnant women, children, youth and other at-risk populations.

The Board maintains a process-based and outcomes-based evaluation of funded programs and keeps State government officials, policymakers, and the general public informed. The Board works with existing partnerships and may create new ones.

SFY 2006 Accomplishments

- Indiana has experienced an amazing level of local smoke free air ordinance activity during the past year. As of June 30, 2006, 23 communities had passed some local smoke free air law.
- The following communities went smoke free: Columbus, Indianapolis, Greenfield, Carmel, Greenwood, St. Joseph County, Delaware County, and Jeffersonville.
- The Americans for Nonsmokers' Rights recognized Indiana as the state with the third most local smoke free air policies passed in 2005.
- More than one-third (36%) of all Hoosiers covered by one of these local laws, an increase from 3 percent in 2000.
- State tobacco control partners developed the "Fundamentals for Smoke Free Air Policy Development for Hoosier Communities", based on the national model. The Fundamentals are recommended guiding principles for developing and implementing effective smoke free policies that help achieve the goal of saving people's lives from the disease and death caused by secondhand smoke.
- Hospitals and health care facilities are leading the charge and setting the example in their community. In 2005, 36 facilities went smoke free on hospital grounds, another 30 hospital and major health centers are implementing tobacco free campuses in 2006, and so far eight campuses are schedule for 2007.
- In June 2006, ITPC collaborated with Indiana Rural Health Association (IRHA) to honor nine healthcare facilities that provide smoke-free locations for Indiana's rural populations through the second annual Rural Indiana Smoke-Free Environment (R.I.S.E.) awards.
- Indiana colleges and universities have also expanded their tobacco use policies on campuses in 2006 including the University of Indianapolis and Ivy Tech campuses system-wide. In August 2006, Indiana University Purdue University at Indianapolis and Indiana University and Purdue University at Columbus and Indiana University at Richmond will make their campus grounds smoke free.
- Progress is being made with schools throughout Indiana as 27 counties have all tobacco free schools districts providing approximately 50 percent of our youth with protection from secondhand smoke at school. Another 36 counties have a portion of their school districts with tobacco free campuses.
- Over 400 participated in the largest training initiative, the Indiana Tobacco Control Partner Information X-Change, "Looking Forward to the Tobacco Free Indiana" on March 1-2. ITPC staff collaborated with Smokefree Indiana, the Hoosier Faith and Health Coalition and members of the Indiana State Partners Network to plan this large statewide event.
- Eighty-eight of Indiana's 92 counties received a grant to conduct tobacco prevention and cessation in their communities, including setting up resources to help smokers quit. Over 2,100 organizations are involved locally, including 15 local and state minority organizations and 7 organizations working on statewide programs.
- ITPC local partners have conducted over 5,750 local program activities ranging from VOICE events to community presentations to training. Partners are implementing prevention and education programs in schools, developing cessation networks, working to protect Hoosiers from second-hand smoke, engaging local businesses in tobacco free efforts, and raising awareness of tobacco prevention activities.

- Approximately 840 presentations given, 360 training activities conducted, more than 360 cessation programs and 200 patient, parent and student education activities performed by local coalitions.

- Six regional Voice Hubs provided ongoing technical assistance for local adults and youth on youth advocacy and support for building and sustaining 53 local Voice movements

- Over 300 youth and adults, from all six Voice hubs and 41 counties, participated in the Voice Leadership Intensive Summer Conference offered by Indiana Teen Institute (ITI) in the summer of 2005.

- From January to June 2006, Voice partners have reported approximately 80 action plans and 40 infrastructure activities.

- Three out of four Hoosier adults recall at least one ITPC anti-tobacco advertisement. Sixty-nine percent of adults could recall at least one television ad.

- Eighty percent of young people in Indiana confirmed they saw at least one ad.

- Youth with confirmed awareness of Voice were 13 times more likely to think that smoking is not cool or that smokers do not have more friends; and were twice as likely to know the dangers of tobacco use.

- ITPC celebrated the fourth annual Tobacco Free Day at the Indiana State Fair. The impact of this partnership continues to improve each year, particularly as the Fairgrounds extends its non-smoking policy to new areas each year. Visitors to the WhiteLies.tv booth were welcomed with a state map highlighting the varying degrees of tobacco-free school policies by county and were encouraged to sign the map as a show of support for the policies. Tobacco Free Day attendees were treated to a motocross show sponsored by Voice as well as an evening concert by the band Switchfoot.

- In the summer of 2005, 36 counties participated in their County Fairs with a Tobacco Free Day and another 32 counties had a booth at the fair, which allowed them to promote a tobacco free lifestyle. Four counties including Huntington, Montgomery, Boone, and Brown took that even further and were able to make the entire fair tobacco free!

- WhiteLies.tv and the Voice movement had a significant presence at Indiana Black Expo's Summer Celebration. National comedienne Rene Hicks hosted the WhiteLies.tv free concert, using the platform to speak about the dangers of smoking, secondhand smoke and how tobacco has affected her life.

- WhiteLies.tv had a large exhibit at the Indiana Black Expo information center, exhibit space within the health fair to distribute materials regarding the dangers of secondhand smoke and tobacco cessation, and inclusion in the Sunday morning church service, where more than 2,000 WhiteLies.tv church fans were shared with the congregation.

- Voice ads, "Drop" and "Raise," were filmed during the fall 2005 statewide youth summit, ACT, and featured Hoosier teens addressing the fact that they refuse to continue to be victims of the tobacco industry and its marketing tactics. A Voice documentary premiered at ACT and is used as a resource for Voice recruitment at the local level, captures the sense of activism that is needed within Voice and gives viewers a glimpse of the variety of Voice activities and participants.

- Nearly 300 teens and 50 adults participated in ACT 2005 in November. The youth created, coordinated and implemented a "drop", signifying the number of Hoosiers killed, or "dropping dead," each day by tobacco use. Summit sessions covered how to work with the media, how to plan and promote an event, and how to recruit participants. Youth were then equipped to go back into their local communities and create similar events that would culminate in a statewide "Drop Dead Day" in May. Adult Ally sessions

focused on sharing ways to help the Voice movement develop as well as learning more about the tobacco industry and how it manipulates teens.

- More than 500 youth in 45 cities from around the state participated in staged events of Drop Dead Day during the first half of May.
- Voice partnered with the DECA Statewide Conference in February. Voice recruited more competitors in its palm card category, designed specifically for Indiana and Voice, where participants were judged on the creativity, originality and messaging of the p romotional piece they designed for Voice.
- ITPC issued 20 news releases, opinion editorial pieces and letters to the editor on a variety of topics.
- Indiana generated more than 3,200 newspaper clips. The more frequent topics of news cove rage we re secondhand smoke, health consequences, coalition partner activities and cessation.
- Bartholomew, Delaware, and Johnson counties logged over 100 newspaper clips. Marion and Tippecanoe counties have over 200 newspaper clips. All of these counties had a smoke free air ordinance campaign at some level during this past year.
- TRIP officers conducted more than 7,500 inspections of retail tobacco outlets, avera ging over 625 inspections per month. TRIP enforcement activities have resulted in s a les ra tes to youth at an ave rage of 9.8 percent for SFY 2006.
- The State Board of Accounts completed 57 monitoring engagements.

The Hoosier Model for Comprehensive Tobacco Prevention and Cessation

The Center for Disease Control and Prevention (CDC) recommends that States establish tobacco control programs that are comprehensive, sustainable, and accountable. Based upon the evidence, specific funding ranges and programmatic recommendations are provided. The recommended funding range for Indiana is $34.8 to $95.8 million. The CDC recommends that States establish tobacco control programs that contain the following elements:

- Community Programs to Reduce Tobacco Use
- Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases
- School Programs
- Enforcement
- Statewide Programs
- Counter-Marketing
- Cessation Programs
- Surveillance and Evaluation
- Administration and Management

The CDC draws on "best practices" determined by evidence-based analyses of excise tax-funded programs in California and Massachusetts and by CDC's involvement in providing technical assistance in the planning of comprehensive tobacco control programs in other states.

The Hoosier Model for comprehensive tobacco prevention and cessation is derived from the Best Practices model outlined by the CDC and required by I.C. 4-12-4. In addition, guidance is provided through recommendations outlined in the Guide to Community Preventive Services for Tobacco Control Programs. This Guide provides evidence of the effectiveness of community-based tobacco interventions within three areas of tobacco use prevention and control: 1) Preventing tobacco product use initiation, 2) Increasing cessation 3) Reducing exposure to secondhand smoke. The Hoosier Model has five major categories for funding and incorporates elements from all nine categories recommended by the CDC.

The Hoosier Model consists of:

- Community Based Programs
- Evaluation and Surveillance
- Statewide Public Education Campaign
- Enforcement of Youth Access Laws
- Administration and Management

Community Programs

Purpose

To achieve the individual behavior change that supports the nonuse of tobacco, communities must change the way tobacco is promoted, sold, and used while changing the knowledge, attitudes, and practices of young people, tobacco users, and nonusers. Effective community programs involve people in their homes, worksites, schools, places of worship, entertainment venues, civic organizations, and other public places. Evaluation data show that funding local programs produces measurable progress toward statewide tobacco control objectives.

Indiana's Effort

Indiana has been nationally recognized for its Community Based Programs that incorporates Minority, School, Cessation, Youth, Training, and Statewide Programs under one broad category because these programs are interconnected and can all be addressed by linking local community coalitions with the statewide counter-marketing program.

In the 2001, ITPC set up its community-based and minority-based grant application process utilizing the American Cancer Society's Communities of Excellence guidelines. The first local partners were funded in December 2001 and as of September 2002; all of Indiana's 92 counties had a tobacco prevention coalition operating. By June 2003, 31 minority-based coalitions were established in 23 Indiana counties.

The fall of 2003 brought a grant renewal process for local tobacco control efforts. ITPC staff conducted statewide trainings on evidenced-based tobacco control interventions. ITPC's commitment to its community programs remained strong, building on the great progress that has been made. ITPC was able to continue the work of coalitions in all 92 counties, with 24 state and local minority based partners working in 25 counties through SFY 2005, as a result of the application process.

In the spring of 2005, staff conducted regional trainings statewide to prepare new and existing grantees for the application process. The new application process was in two parts. Part I gave the partners an opportunity to demonstrate the strength and vitality of their coalition efforts as well as take the initial steps to begin writing future work plans.

In the fall of 2006, Staff guided the Part 1 approved partners through training on Part 2, the Implementation Grant, which included the work plan and final budget for SFY 2006-2007. This resulted in the funding of 88 of the 92 counties with a community-based coalition, and 15 minority-based coalitions from 12 counties.

The partners are working on four intervention areas:
1) Decreasing youth smoking rates;
2) Increasing proportion of Hoosiers not exposed to secondhand smoke;
3) Decreasing adult smoking rates; and
4) Protecting and maintaining a state and local infrastructure necessary to lower tobacco use rates

Local coalitions also provide training opportunities to establish a solid foundation in tobacco control knowledge and the tactics of the tobacco industry. They have significantly increased advocacy activities related to tobacco free schools and secondhand smoke policies.

The new element of the program for 2006 was the addition of the Special Opportunities Grant. Only community-based and minority-based grantees currently funded through ITPC are eligible for the special opportunity grant project. The projects must fall into one of the following categories:
- Community public education campaign on smoke free air.
- Implementation of city or county smoke free air ordinances.
- Voice paid advertising in conjunction with Voice Hubs
- Education of community business leaders
- Scholarships for in-state tobacco control training

The community programs are evolving into strong and influential forces in the statewide tobacco control movement. Their work in the local communities is vital to the success of the statewide program, and ITPC is committed to the local community programs by providing training, technical assistance and resources. Over 2,100 organizations working on tobacco control through the ITPC network of community programs in Indiana. See the appendix for summaries of each county and the coalitions working in those counties.

In addition to the local partnerships, the statewide projects increase the capacity of local programs by connecting local and statewide partners and resources (especially youth resources), promoting media advocacy, implementing smoke free policies and best practices for cessation services. Supporting organizations that have statewide access to diverse communities can help eliminate the disparities in tobacco use among the State's various population groups. Programs that successfully assist young and adult smokers in quitting can produce a quicker, and probably larger, short-term public health benefit than any other component of a comprehensive tobacco control program. These projects have a broader focus to fit with ITPC's vision and mission as well as enhance the efforts occurring at the local level.

Statewide Programs

ITPC Statewide partnerships use evidenced-based tobacco prevention and cessation efforts for youth and adults. These programs are implemented by diverse partner organizations throughout the State complementing and enhancing the efforts of the local programs. All grantees have been coordinating and linking with ITPC to deliver a unified and strengthened message across the State that is carefully coordinated with ITPC community-based and minority-based grant recipients. Approximately $500,000 dollars were awarded to the following organizations for SFY 2006-2007.

Clarian Tobacco Control Center: Nurse-to-Nurse: This Clarian Tobacco Control Center project utilizes nurses to recruit and mobilize other nursing professionals. A website designed for Indiana nurses and students help them quit smoking; provide cessation counseling education to better assist patients in quitting; tools to help with this; advocacy resources and directory of cessation service providers. The objectives include: 1) encourages Clarian Health Partners or affiliate nurse that smoke to make at least one quit attempt or reduce their smoking; 2) support and encourages the implementation of the Public Health Service Guidelines; 3) increase the involvement of nurses in tobacco control policy efforts at the community level by recruiting and sustaining parish and hospital-based nurses. Clarian has also developed and maintains an electronic resource through their Clarian Tobacco Control Center website that links individuals with cessation services in each county.

Indiana Academy of Family Physicians Foundation: The Indiana Academy is conducting the Tar Wars Program. Tar Wars® is a pro-health tobacco prevention and education program for fifth grade students. The key elements of the program are its interactive format, community involvement, and education by health care professionals. Family physicians, family medicine residents, medical students, school nurses, physician assistants, nurse practitioners, community leaders, and other health care professionals visit fifth grade classes to present an interactive curriculum that addresses the effects of tobacco use. Their direct involvement builds capacity for healthcare professionals to conduct tobacco control in the community. The Tar Wars program directly addresses tobacco advertising in print and the movies and enables the student to see the misinformation – smoking cigarettes causes yellow teeth, costs money, and is harmful to the human body.

Indiana Alliance of Boys and Girls Clubs: The mission of the Boys & Girls Clubs of America and the Indiana Alliance of Boys & Girls Clubs is to work toward helping the youth of all backgrounds, with special concern for those from disadvantaged circumstances, develop the qualities needed to become responsible citizens and leaders. Boys & Girls Clubs across Indiana raise the involvement of SMART Leaders, young people whose skills in education,

mentoring and advocacy were first developed under the SMART Moves program. SMART Moves a nationally recognized program encompassing instruction and skill building activities, parental involvement and community support, to extend the anti-tobacco message throughout their clubs and into the community by forming a strong a partnership with Voice. Such participation will increase access to resources available to spread the anti-smoking message, and furthermore enhance their leadership skills by sponsoring their attendance at the Indiana Youth Leadership Institute as Voice representatives.

Indiana High School Athletic Association (IHSAA): IHSAA has developed and is implementing a communications network to reach student athletes, teachers, coaches and administrative staff with a tobacco free message. The role model program highlights student athletes from a local community on a poster and pocket schedule. These youth are committed to be tobacco free and become spokespersons for Voice. These spokespersons attend training provided by Indiana Teen Institute and are exposed to the Voice youth movement. Youth speakers will then provide talks to youth and adults in school and community settings; as well as on the high school sports radio networks. Goals of the project are to 1) provide peer education from the HS youth to the MS youth on the dangers of tobacco use; 2) provide community education; and 3) increase awareness of the tobacco industry marketing practices. This grant cycle school districts that do not have a tobacco free policy have been targeted for this program.

Indiana State Fair Commission: The Indiana State Fair provides a statewide platform to enhance ITPC's public education campaign to a large and diverse population showcasing Voice. The partnership educates the public on tobacco control issues in an entertaining environment, including Tobacco Free Kids Day at the Indiana State Fair. The project objectives include 1) increasing smoke free worksite policies; 2) increasing the number of employer-sponsored cessation services; 3) promoting community activism among youth through supporting efforts of Voice; and 4) stimulating outreach to groups disparately affected by tobacco use. For SFY 2006, the State Fair planned an expansion of the tobacco free policy to the Pfizer Fun Park. Promotion of tobacco cessation services and encouragement is provided to seasonal and year-round employees.

Indiana Teen Institute (ITI): ITI supports youth-led, youth-driven advocacy initiatives that strive to change the cultural perception and social acceptability of tobacco use in Indiana and prevent initiation of tobacco use by youth. A youth development approach provides youth with meaningful opportunities to participate and learn new skills and support in their effort from adults. Summer sessions provide training and technical assistance, and support for local tobacco control coalitions in youth efforts. Project objectives focus on fostering awareness of tobacco issues; developing youth-led advocacy initiatives that correspond to the Voice message; creating action plans for local community events for change; and empowering youth to engage in local efforts to create change.

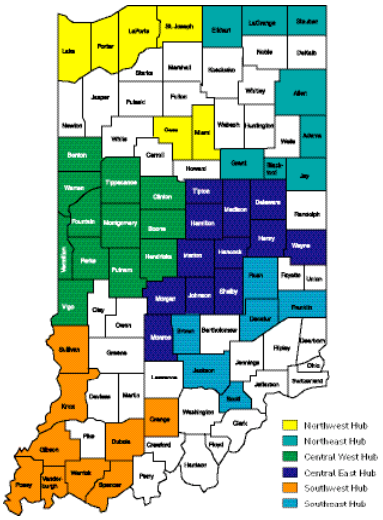
Ruth Lilly Health Education Center (RLHEC): The Ruth Lilly Health Education Center is a comprehensive health education facility with engaging education programs that include unique computerized exhibits, high-tech audio-visual aides, Interactive curricula, and 3-D models. This project will target 7th grade and high school youth. Its purpose is to increase knowledge about tobacco use and provide stills to help with avoid tobacco use. Teachers will be provided with resources for further instruction after the visit to the center. These resources will include information about secondhand smoke and smoke free air policy. During this grant 12,000 youth will be targeted in the central Indiana counties, in addition to Cass County through a Logansport facility.

Voice Hubs

The regional Voice Hubs provide leadership for a regionalized, ongoing training and capacity building network for communities that will sustain the momentum of the VOICE movement at the grassroots level which will ultimately result in a successful statewide movement. This project strengthens existing communication, marketing and networking resources.

The Voice Hub Coordinators gained strength and momentum in 2006 to provide training and recruitment for adults and youth, centralize communications, plan events and provide a forum for networking the youth message across the state.

2005-2006 voice hub regions



Six regional Voice Hubs, representing 53 partners were working in SFY 2006. Each hub provides continual technical assistance for local adults and youth on youth advocacy and how to build and sustain their local Voice movements.

Every hub has implemented at least two capacity building sessions for both Voice adult allies and Voice youth through the assistance of the Indiana Teen Institute. The hubs strengthen existing communication, marketing and networking systems through earned media, resource development, and weekly contact with all partners.

Over 300 youth and adults, from all six hub regions and 41 counties, participated in the Voice Leadership Intensive Summer Conference offered by ITI in the summer of 2005. Participants learned multiple strategies for effectively promoting tobacco control messages. The Voice Hubs conducted Adults as Allies, Media Literacy and Advocacy, Media Blitz training, Teen Against Tobacco Use (TATU) training and the Leadership Intensive Training for approximately 460 youth and 140 adults. The concept of the hubs allowed for standardized, consistent training to the youth and adults. Since January 2006, approximately 80 action plans and 40 infrastructure activities have been reported by Voice partners.

Through the Voice Hub structure over 50 local events and three regional events in addition to "Drop Dead Day" were conducted. Some examples include:

- Youth from Fountain/Warren counties had a letter to the editor published in the Review Republic about the 50th birthday of Marlboro and their planned celebrations.
- Nine counties in the West Central Hub completed and distributed a "Voice: Your Choice" newspaper tailored for their community. Voice youth wrote articles about tobacco industry marketing and secondhand smoke to raise awareness of Voice and tobacco concerns in their counties.

More details about how Voice is getting their message out in Indiana see page 96 in the **Public Education Campaign** section.

Findings

Local community-based and state and local minority-based programs

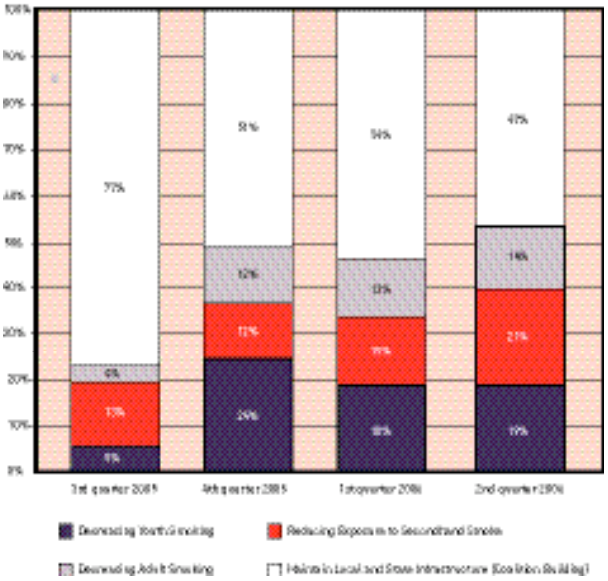
The community program progress is tracked through a variety of mechanisms. This includes monitoring the implementation of activities as well as evaluating their effectiveness in working towards ITPC's objectives. ITPC tracks how local coalitions implement activities through a web-based program tracking system. Each coalition has a unique login to access the system and report electronically. Through this reporting system ITPC can track local program activity level. Coalitions have reported 5,750 local program activities in SFY 2006, ranging from VOICE events to community presentations to delivering training. In SFY 2006 , these include activities such as:

- Approximately 840 presentations to local communities
- Approximately 360 training activities
- More than 360 cessation programs and over 200 patient, parent and student education activities

Local coalitions distribute their time working among the four priority areas discussed above; 1) Decreasing youth smoking rates; 2) Increasing proportion of Hoosiers not exposed to second-hand smoke; 3) Decreasing adult smoking rates; and 4) Protecting and maintaining a state and local infrastructure necessary to lower tobacco use rates.

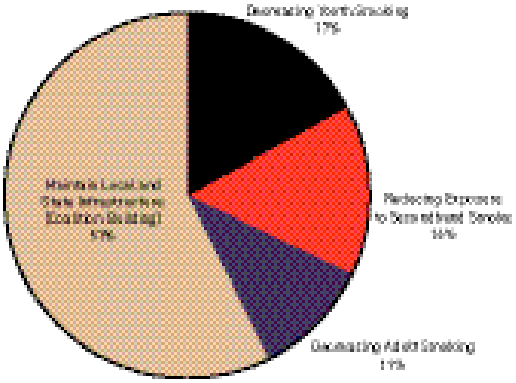
Many coalitions are getting youth involved as they work on priority area of **Decreasing youth smoking rates.** Youth that do not start to smoke before the age of 19 are more likely to remain smoke free for their lifetime. Recommended strategies for preventing youth from starting to smoke include increasing price of tobacco products, strong media campaigns, and smoke free environments. All of these strategies are working in Indiana. The cigarette tax increase is having an impact as youth are more sensitive to price increases. The local communities complement these statewide strategies with leveraging local media and establishing networks that support youth in their decision not to smoke. Voice, Indiana youth speaking out against big tobacco, is one way coalitions are supporting youth and letting their voice be heard to stop the devastation of tobacco use. More smoke free public places and workplaces impacts on the number of youth who start smoking. Approximately 17 percent of reported activities at the local level were focused on youth prevention strategies.

Chart 34: Local Tobacco Control Program Activity by Quarter, SFY 2006



Building strong partnerships was the priority area where a majority of the local coalitions are working, however this shifted throughout the year with more focus on protecting Hoosiers from exposure to secondhand smoke.

Chart 35: Local Tobacco Control Program Activity by Priority Area, SFY 2006



Overall in SFY 2006, coalition building and maintaining state and local infrastructure was the priority area where a majority of the local coalitions are working.

Overall, the coalitions throughout the State have increased the number of voluntary and legislated smoke free policies in worksites, government buildings, recreational facilities, and restaurants with over 130 such policy changes occurring in SFY 2006 . Current policy status of various venues and communities can be found in the policy tables in the Appendix. This tobacco control strategy is central to priority area of **Decreasing Exposure to Secondhand Smoke.** Several coalitions are continuing to educate their communities on the dangers of secondhand smoke and that they can make a difference and enact smoke free air policies that would protect everyone. Local partnerships increased their time in this area throughout SFY 2006.

Through implementing these strategies, Indiana communities are changing social norms, creating a tobacco free culture in Indiana. Through smoke free air policies and increasing the price of tobacco, more people want to quit and need help quitting. Local coalitions are providing these resources through work on priority area of **Decreasing Adult Smoking Rates**. While tobacco use is an addiction, people can quit with help. Setting up cessation networks and policies are key to changing how cessation is delivered throughout the community. These local networks are key to the meeting the demand for tobacco users who are ready to quit smoking. Local coalitions reported that approximately 11 percent of their time on decreasing adult smoking in SFY 2006. In addition to these local services, nearly 2,000 "How to Quit Packet packets have been requested through the 1.866.515.LIFE toll free line and www.WhiteLies.tv website, 185 were requested in SFY 2006. ITPC mails out a get started packet to the individual who is interested in quitting smoking or to a family member or friend that they would like to encourage to quit. In addition, the local ITPC partner is notified that someone in their county is interested in quitting smoking and the local coalition follows up with the individual to see if their cessation needs are being met.

Finally, in order to continue to raise awareness of the impact of tobacco use at the local level, communities must maintain coalition efforts through priority area of **Maintaining a State and Local Infrastructure Necessary to Lower Tobacco Use Rates.** These activities include training of coalition and community members, adults and youth; developing relationships with key stakeholders and decision makers in their communities; and building diverse coalitions in their community. The ITPC funding provided the resources to hire staff, purchase education materials and resources, conduct training programs, and recruit and maintain local coalitions. The formation of coalition has been a powerful and effective tool to mobilize the community to make the change that support tobacco control efforts. These coalitions also have become the central focus in organization networks of partners through a large community. While the reported time for these type of activity has declined throughout SFY 2006, approximately 57 percent, or a majority of activity reported was spent in this priority area.

School and Community Speakers

Rick Stoddard
Rick Stoddard and his story about losing his wife to smoking diseases when she was only 46 years old is featured in some of the ads in the media campaign.

ITPC has expanded efforts to reach Hoosiers, and particularly young Hoosiers, through sponsored speakers during school convocations, community town hall meetings, community events and local media. Rick delivers a compelling "no-lecture" message as he tells the story of his wife Marie and her death due to smoking. His message is particularly effective in the rural area of Indiana that is often difficult to penetrate through traditional media avenues.

Since 2002, Mr. Stoddard has personally spoken to approximately 350,000 Hoosier youth in more than 76 Indiana counties. Rick reached 30,800 in the 2005-2006 school year. Rick is heavily involved in inspiring youth to fight against the tobacco industry at the ITI Summer Conference.

Training

ITPC continues to enhance a comprehensive training plan for staff, board, and partners, that includes mandatory training sessions, elective training topics, an annual information-sharing event, bimonthly conference calls, cluster meetings, national presentations, and numerous communication tools. ITPC is committed to providing its partners with training needed to implement their local tobacco control programs by adapting content and material to meet experience level of the communities. These training methods allows ITPC to disseminate the latest evidence based research and applications in tobacco control. ITPC continues to intentionally seek out logical partnerships for training opportunities. Training highlights include:

- System of "cluster" meetings for the partners, dividing counties into 4-5 counties per cluster. The ITPC Regional Directors customize and conduct the cluster meetings at least quarterly with input from the partners.
- Comprehensive conference call/technical assistance structure for all partners that include national, regional and local presenters as well as an opportunity for regular information sharing and problem solving among partners.
- Monthly e-newsletter for its partners to highlight local activities, share new tobacco control resources, and keep them up to date on future events.
- Regional training workshops and elective trainings workshops are continually offered to meet the needs of the partners.
- Partner organization with the state addictions conference, Many Voices One Vision.
- ITPC partnered with the American Cancer Society and The American Heart Association to conduct a series of regional workshops on secondhand smoke policy campaigns. More than 100 participants from several statewide organizations attended these workshops.
- More than 360 local and state training activities were recorded for SFY 2006.
- ITPC partnered with the Indiana State Personnel Department to provide cessation services to state employees in Indianapolis and around the state through the grantees
- Indiana partnered with The Praxis Project and the Indiana Minority Health Coalition to provide policy advocacy training to the partners working in the minority communities.

Figure 10: SFY 2005 Training Calendar

July	August	September	October	November	December	January	February	March	April	May	June
East Central Hub, Leadership Intensive, 19-23	Regional RFA Part 2 Training, Kokomo, 24 Regional RFA Part 2 Training, Plymouth, 25 Regional RFA Part 2 Training, Terre Haute, 30 Regional RFA Part 2 Training, Seymour, 31	Planning for an Ordinance Campaign – the NY Story (Russ Sciandra, Center for a Tobacco Free New York), Indianapolis, 8 Conference Calls 20-21	Project LEAP, St. Louis University 6 New Coordinator Training, Indianapolis, 27	Voice Summit, Indianapolis, 19 Conference Calls 29-30		Conference Calls 17-18 Adults As Allies, SW Voice Hub, Franklin, 25	West Central Hub, Capacity Building 25 Media Advocacy, Indianapolis, 28	Partner Information X-Change, 1-2 East Central Hub, Adults As Allies, 2 Policy Advocacy Training for Minority Partners (Makani Themba Nixon, Praxis Project), 22	Northeast Hub, Adults As Allies, 20	Policy Deal Breaker Training (ACS, AHA, ITPC), Indianapolis, 4 Policy Deal Breaker Training (ACS, AHA, ITPC), Sellersburg, 9 Policy Deal Breaker Training (ACS, AHA, ITPC), Valporaiso, 23 Conference Calls, 16-17	

Best Practices in Tobacco Cessation Counseling-Certification Program

In April, ITPC teamed up with the Clarian Tobacco Control Center to launch a program course for anyone interested in counseling tobacco users wanting to quit. The purpose is to provide a standardized of tobacco cessation counseling for all health care professionals offering services to help tobacco users quit. This ensures that professionals providing these services are applying the guidelines outlined by the U.S. Department of Health and Human Services, Public Health Service Clinical Practice Guidelines for Tobacco Cessation.

The electronic certification program, located at www.BestPracticesITPC.org, offers state-of-art cessation training. The 12-hour course:

- Educates participants on the basics of nicotine addiction
- Offers guidance for implementing a tobacco cessation treatment plan
- Gives insight into special populations of tobacco users; pregnant users, teens, cigar and smokeless tobacco users
- Discusses office management and reimbursement issues
- Reviews public health and policy issues
- Formulates relapse prevention plans
- Provides interviewing and counseling guidance or working with tobacco users.

Beginning with the SFY 2006-2007 grants, all ITPC-funded cessation providers must become a Certified Tobacco Cessation Counselor.

Indiana Tobacco Control Partner Information X-Change. "Looking Forward to the Tobacco Free Indiana," March 1-2, 2006

The largest training initiative in 2006 was the Indiana Tobacco Control Partner Information X-Change, in newly 100% smoke free Westin Hotel in Indianapolis. ITPC staff collaborated with Smokefree Indiana, the Hoosier Faith and Health Coalition and members of the Indiana State Partners Network to plan this significant, momentus statewide event. Objectives for the event were to:

- GET excellent training
- EXCHANGE information and strategies
- DO tobacco control advocacy while attending the meeting
- BUILD toward the Governor's Summit on Smoking

The X-Change kicked off with a keynote from world-renowned researcher and secondhand smoke activist, Dr. Stanton Glantz, from the University of California San Francisco. Tobacco control advocates celebrated the first day of a smoke free Indianapolis and Greenfield, with a news conference style presentation that involved powerful story telling from local policy-makers, business leaders, and individuals impacted from the effects of secondhand smoke. Participants were then unleashed into downtown Indianapolis to enjoy smoke free dining and thank restaurants for going smoke free!

The afternoon sessions included skill-building workshops by local advocates and how they are passing smoke free policies, involving youth, and reaching priority populations. These hands on workshops for "Looking Forward – A Tobacco Free Future for Indiana" included:

- Secondhand Smoke – Hoosier Communities Share How to Get It Done (Moderator: Kara Endsley, Director of Special Projects, Indiana Black Expo; Peggy Voelz, Coordinator of Tobacco Prevention Programs, Bartholomew County; Nicole Toran, Floyd/Clark Minority Tobacco Prevention and Cessation, Community Action of Southern Indiana; Jon Clark, Councilman, City Council of Greenfield; Brandee Bastin, Tobacco Initiative

Coordinator, Hancock Regional Hospital; Matt Phelan, Smokefree Air Specialist, American Cancer Society)

- Pitfalls & Arguments in Secondhand Smoke Campaigns – How to Avoid Them (Aaron Doeppers, Regional Advocacy Representative, Campaign for Tobacco-Free Kids; Bronson Frick, Associate Director Americans for Nonsmokers' Rights; Micah Berman, Executive Director, Ohio Tobacco Control Policy Center)

- New Technologies in Tobacco Cessation (Erin Slevin, Director of Cessation Initiatives, Smokefree Indiana; Deborah Hudson, Program Manager, Clarian Tobacco Control Center; Kim Litkenhus, Southwest Voice Hub Coordinator, Smokefree Communities

- Addressing Tobacco Use Among Priority Populations (Jan Arnold, MS, State Director of Program Services/Public Affairs, March of Dimes; Jill Thomas, Program Coordinator, Indiana Youth Group; Amelia Munoz, Program Director, Indiana Latino Institute; Virginia Pullins, Medical and Wellness Coordinator, Head Start Program, Family Development Services)
- Keep It Real – Secondhand Smoke Messages for Communities of Color (Ronald Kwesi Harris, Membership Chair, National African-American Tobacco Prevention Network

- Getting the Business Community Involved (Mike Campbell, President, CLS Benefit Solutions,Inc.; Janet Lewis, Senior Manager, Marketing Partnerships and Sponsorships, Starwood Hotels and Resorts; Bruce Bryant, CEO, Promotus Advertising)

- What It Takes To Get Funded By Local Organizations (Olga Villa Parra, ITPC Advisory Board; Steve Everett, Program Officer, The Health Foundation of Greater Indianapolis, Inc.; Rhonda Kessler, RN, Putnam County Health Department; Heidi Frederick, Research Development Specialist, The Center on Philanthropy at Indiana University)

- Rural Strategies: Country Roads to Tobacco-Free Communities (Joanie Perkins, Daviess Community Hospital; Sheila Evans, Bloomington Hospital and Healthcare System; Louise Anderson, Vigo County Health Department; Muff Rennick, Program Director, Community Action Program)

- Increasing the Power of Youth to Create Permanent Change -- Beyond Events (Julianne Stewart, Project Director, Indiana Teen Institute; Mark Kaser, Program Director, Indiana Teen Institute)

- From Schools to Hospitals – Laying the Groundwork for Change (Jennifer Riley, Coordinator, Harrison County Tobacco Prevention; Vanessa Smith, Coordinator, Clark County Tobacco Prevention & Cessation Coalition; Dan Hodgkins, Vice President of Promotions Services and Community Development, Community Health Network; Jeanne Calvert Kuhn, Hancock Memorial Hospital)

A special luncheon for a small group of tobacco control researchers was held with Dr. Glantz to exchange ideas for move forward the science of tobacco control efforts in Indiana. The first evening concluded with "Laugh your BUTTS off II", an event featuring comedienne Rene Hicks.

The next morning led with a program of national experts talking about what the tobacco industry is doing in our backyards from Danny McGoldrick, Director of Research from the National Campaign for Tobacco Free Kids. The participants learned just how much tobacco companies knew about the dangers of secondhand smoke from Dr. Suzaynn Schick, Center for Tobacco Control Research and Education, University of California – San Francisco. Finally, Ronald Kwesi Harris, Membership Chair, National

African-American Tobacco Prevention Network fired up the crowd to fight back against the industry's targeting of our communities. Following this participants selected from a variety of "round table" discussions to hear or share about the particular topic. This is a great chance for tobacco control advocates to share among each other and get energized before heading back to their communities.

The luncheon, *Visioning for a Tobacco Free Indiana,* was a joint effort with faith leaders from the Hoosier Faith and Health Coalition (HFHC). This lunch included an awards presentation from the HFHC honoring Hester Schultz and Paul Messplay. ITPC honored the first Youth Advocate of the Year Awards (YAYA) to four regional winners: Cathy Blume (West Central), CastleTeen Power (Southwest), Paige Noble (Northeast), and Curtis Merlau (East Central). Curtis Merlau was presented with the State award for his exceptional efforts in Hancock County. With the honor of becoming the state recipient, Curtis was also considered for the National Youth Advocate of the Year Awards, sponsored by the Campaign for Tobacco-Free Kids. This program honors the outstanding work of young advocates who have taken the lead in holding the tobacco industry accountable for their efforts to market their products to youth.

The afternoon sessions gave the community tobacco control advocates an opportunity to work with their faith leaders. The workshops included:

- Advocacy in the Faith Community -- Reducing Tobacco Use (Brenda Graves-Croom, Project Coordinator, Indiana Latino Institute; Kara S. Endsley, Director of Special Projects, Indiana Black Expo; Amelia Munoz, Program Director, Indiana Latino Institute)

- Reaching Out to the Faith-Based Community -- Programs that Work! (Aaron Doeppers, Regional Advocacy Representative, Campaign for Tobacco-Free Kids; Pastor Ron Kelly, Indiana Seventh-Day Adventists; Rev. Dan Gangler, Director of Communication, Indiana Area of the United Methodist Church; Paul Messplay, Tobacco Control Advocate, Hoosier Faith & Health Coalition; Rev. Clarence Moore, Senior Pastor, Northside New Era Missionary Baptist Church)

The 2006 Partner Information X-Change was a tremendous success with the help of dozens of state and local tobacco control partners. Individuals left recharged and energized to take what they learned back to their communities to make Indiana healthier and tobacco free.

Indiana Tobacco Quitline

Quit Now... We'll Show You How!

In 2006, Hoosiers smokers were given a new resource to help them quit smoking, the Indiana Tobacco Quitline. Smokefree Indiana (SFI), received a two-year supplemental grant of $250,000 annually from the CDC for states that did not have a quitline. SFI lead the effort to select a quitline vendor and establish Indiana's first tobacco quitline!

Launched on March 22, 2006, the Indiana Tobacco Quitline is a free service available for all Hoosiers to access for help in quitting smoking through a telephone-based counseling. The quitline is one part of a comprehensive tobacco cessation network of services and provides referrals to local community partner cessation services when appropriate.

Multiple scientific reviews have established that proactive telephone counseling through quitlines is an effective cessation method. The U.S. Public Health Service Clinical Practice Guidelines and the Guide to Community Preventive Services both recommend quitlines as an effective method to help people stop smoking. Also, the state-managed quitlines form a national tobacco quitline network, which is a federal initiative created by former Health and Human Services Secretary Tommy Thompson.

One of the goals of a quitline is to increase the number of people who attempt to stop using tobacco, as well as increase the number of people who are tobacco free. The quitline, along with tobacco cessation and prevention efforts, policy changes, restriction of access to tobacco, and preventing youth initiation of smoking, are critical to decreasing tobacco-related diseases and deaths in Indiana.

Any Indiana resident can call the Indiana Tobacco Quitline. The quit line provides support for people who want to stop smoking or using other tobacco products; offers information on tobacco dependence for health professionals, and families or friends of tobacco users; and provides information on community or national cessation resources. Registration staff request brief demographic information from callers such as age, smoking history, and zip code; however, all calls are confidential.

Due to funding, initial services provided were limited. Initially, all adult tobacco users received a single, comprehensive counseling intervention and printed materials. Those not interested in quitting or counseling receive stage appropriate materials and encouragement to call back when ready.

Beginning July 1, services were expanded to provide extensive counseling interventions to priority populatios in Indiana: Medicaid-insured, uninsured and pregnant women (regardless of insurance status). Due to a large increase in volume during our first month of services, the Indiana Tobacco Quitline had to limit the extensive counseling services to pregnant women only, while providing quit kits and referrals to local resources for all other Indiana residents. Depending upon volume experienced in the future, services may be reinstated.

Smokefree Indiana contracted with Free & Clear, Inc., a highly specialized tobacco treatment provider for health plans, employers and government organizations. Free & Clear helps its customers improve the health and productivity of their populations and control related costs by reducing the prevalence of tobacco use. More than 50 million people have access to the Free & Clear Quit For Life Program, which is the only commercial tobacco treatment program in the United States with proof of effectiveness published in multiple peer-reviewed, scientific journals over the course of nearly 20 years.

Early Results

With no formal evaluation data regarding the quit rates and satisfaction of participants in the Indiana Tobacco Quit line program, the monthly reports provide data that give aggregate information regarding total volume, caller type,

pregnancy and insurance status of callers to the Quitline, services provided to participants.

Between March, 22 to June, 30, 2006, just over 3,500 calls came in through the Indiana Tobacco Quitline (1-800-QUITNOW) and data show that:

- 92 percent of callers were tobacco users, 5 percent were proxy, 4 percent were providers.
- 59 percent of tobacco users were female and 95 percent were not pregnant.
- A majority of callers were between the ages of 31-60 with 28 percent ages 41-50; 20 percent ages 31-40, and 18 percent ages 51-60. Approximately 10 percent were ages 18-24 years old.
- Approximately one-third of callers had a high school degree (33%), another 29 percent notes some college or university education, with 17 percent without a high school education.
- 63 percent of callers requested an intervention.
- 83 percent of tobacco users requested an intervention, 75 percent completed the intervention live with a quit coach.
- 2 percent of tobacco users who requested an intervention were pregnant, 2 percent completed the intervention live with a quit coach.
- 29 percent of tobacco users were uninsured.
- 15 percent of tobacco users were covered by Medicaid.

Promotional efforts were successful and effective considering the short period of time in which Smokefree Indiana launched the Quitline and drove volume to it in order to assist as many tobacco users as possible. Their endeavors in the area of provider education resulted in increasing numbers of participants referred to the Quitline by their provider. Tagging ITPC's TV ad with the Quitline phone number (24%), radio ads (27%), and PSA's included the primary ways people heard about the quit line. Health professionals were also a strong way to get information out about the quit line with 11 percent of callers noting this method. In addition, print ads and involving their community partners in the use of these as well as other Quitline promotional tools resulted in increased awareness of and volume to the Quitline. A dramatic spike in volume (more that 300 percent increase) in the last four days of the contract period concluded the year on a very positive note, allowing Smokefree Indiana to experience complete expenditure of their funds as well as reach a greater number of Tobacco Users than anticipated.

Future Direction

The need for the Indiana Tobacco Quitline in Indiana certainly exists. A major goal of the quitline is to increase funding to expand cessation services to reach more Hoosier tobacco users. The Indiana Tobacco Quitline also plans to continue to work with healthcare providers to educate them about the use of the fax-referral system. The quitline will also use evaluation results to educate others on the effectiveness of quitlines and garner increased funding for the program through public-private partnerships.

Evaluation and Surveillance

Purpose

A comprehensive tobacco control program must have a strong evaluation component in order to measure program achievement, improve program operations, manage program resources, ensure funds are utilized effectively, and to demonstrate accountability to policymakers and other stakeholders. Program evaluation is conducted in two ways: Surveillance and Evaluation research. Surveillance is the monitoring of tobacco-related behaviors, attitudes, and health outcomes in which data is collected on a routine basis. Evaluation research employ surveys or data collection systems specifically designed to measure specific program activities. These two methods complement each other to allow program administrators to assess progress toward program objectives.

Indiana's Efforts

The ITPC commitment to evaluation is center to its programs. ITPC continued to work with an independent Evaluation and Research Coordinating Center, American Institutes for Research (AIR). AIR team includes: AIR, Stone Research, Briljent and the Indiana Minority Health Coalition. It also included researchers from Indiana-based universities including Indiana University and the Bowen Research Center, and Ball State University. AIR implemented the evaluation plan for Indiana's comprehensive program with a set of measures with various data sources to evaluate the impact programs are making in achieving the ITPC mission and objectives. In addition to continuous program monitoring, Indiana has secured the services of the State Board of Accounts' Field Auditors to conduct compliance checks of fiscal responsibilities of all tobacco control program grant dollars. All information gathered through the ITPC Evaluation and Research Coordinating Center is used to improve programs by making adjustments when they may be needed and enhancing components in areas that are already working.

Findings

Indicators the ITPC's evaluation plan demonstrate that Indiana is on track with intermediate and short term objectives to reducing tobacco use among Hoosier youth, however, we are backsliding among adults. As discussed earlier in this report, troubling data from the 2005 Behavior Risk Factor Surveillance Survey shows the reversal in the decline of smoking among adults from 27.7 percent in 2002 to 24.9 percent in 2004. The new data shows that Indiana's adult smoking rate increased to 27.3 percent. While this change is not statistically significant, it does show a trend in the wrong direction and is an indicator of reduction in programming due to budget cuts. Further analysis of specific sub-populations also indicate a serious concern, as young adults ages 18-24 and Hoosiers without a high school education, especially men, have alarmly high smoking rates.

In addition, consumption of tobacco products increased 3 percent in SFY 2006 from the previous year. The dramatic decrease in consumption occurred between SFY 2002 and SFY 2003 due to the tax increase of 40-cent increase that took effect in SFY 2003. The impact of the tax on cigarette consumption has slowed since SFY 2003, as Indiana's tax is lower than the current average cigarette tax for all states is 95.3 cents.

While we are working to change social norms around tobacco, progress is a challenge with a diminished public education campaign. Long held attitudes must be changed before we see our tobacco use behaviors change. Coalitions continue to work hard in their communities as all Hoosiers learn more about the burden tobacco places on us all. This will continue with the implementation of the 2010 Strategic Plan. The following includes highlights from the ITPC Program Evaluation efforts.

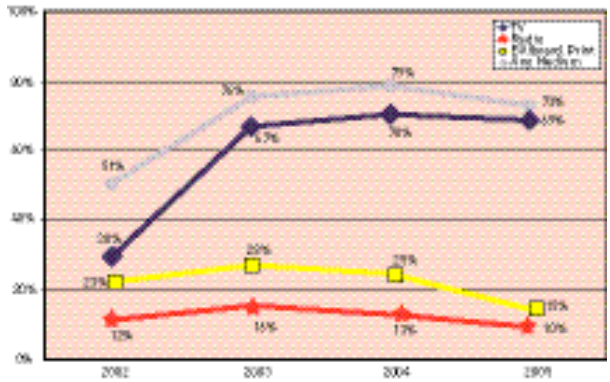
Media Tracking Surveys

Media Tracking Surveys were conducted to evaluate the effectiveness of the statewide public education campaign. This survey has adult and youth components and serves to evaluate the progress of the Voice youth movement, the "WhiteLies" campaign and the sponsorship activities of these campaigns.

Baseline data was collected prior to the launch of the statewide campaign and follow up surveys are conducted to see what knowledge and attitude changes had occurred in youth and adults. Each survey, one youth and one adult, surveys approximately 1000 people, including an over-sample of African Americans and Latinos. These additional respondents allow ITPC to evaluate its ethnic marketing focus.

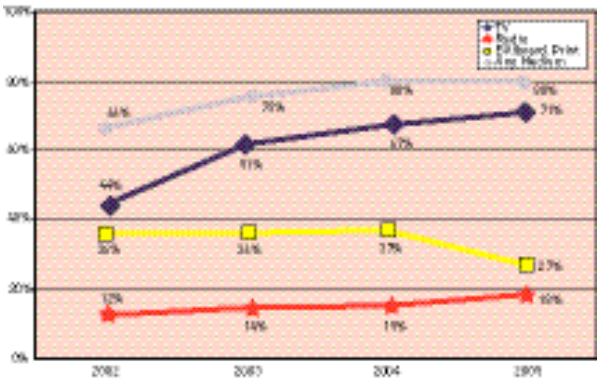
The most recent surveys were conducted in June-July 2005 and measured overall campaign awareness, as well as knowledge, attitudes and beliefs on tobacco-related issues as the media campaign works to shift these beliefs to anti-tobacco. Advertisement awareness is the first major step in an effective campaign because people must be aware of advertisements to be influenced by them. Findings from other state and national campaigns suggest that advertisement awareness increases anti-tobacco knowledge, attitudes, and beliefs, leading to reductions in cigarette smoking.

Chart 44: Awareness by Adults of at least one ITPC Advertisement by Medium, 2002-2005



Seven out of ten Hoosier adults have seen an ITPC ad, a significant increase in confirmed awareness since 2002. However, this is a slight overall decrease from 2004 and a significant decrease in awareness of billboard/print medium from 2004.

Chart 45: Awareness by Youth of at least one ITPC Advertisement by Medium, 2002-2005



Eight out of ten Hoosier youth have seen an ITPC ad, a significant increase in confirmed awareness since 2002. There was a significant decrease in awareness of billboard/print medium from 2004.

Overall awareness of the campaign measured in the 2005 survey remained at similar levels to previous years, despite substantial cuts in the advertisement budget. Per capita spending on the public education campaign had dropped from $0.86 in SFY 2004 to $0.54 in SFY 2005 and even further in SFY 2006 to $0.27. The CDC recommends that Indiana spend a minimum of $1.00 per capita for public education campaigns.

In addition, the campaign was not on air again until late spring 2006, marking the first major gap in media flights since the campaign launched in 2001. The frequency, as well as the scope of the campaign was reduced significantly in SFY 2006. Data to be collected in late 2006 will help measure the impact of this gap.

In 2005, three out of four Hoosier adults (73.2%) can recall at least one ITPC anti-tobacco advertisement. Sixty-nine percent (69%) of adults could recall at least one television ad. Whereas confirmed awareness for any medium and television and billboards did not change from the previous year, awareness of radio declined significantly from 2004, reflecting smaller media buys.

Analysis of the data looks at the public education campaigns effects on changing knowledge, attitudes, and beliefs. The survey also asked a series of questions about the acceptability of smoking by family and friends. These questions were combined into a global measure of social acceptability. In 2005, 52 percent of Hoosier adults believed that their family would prefer them not to smoke and 35 percent thought that their friends would not want them to smoke, both findings significantly higher from the baseline results (41.1% and 28.6%, respectively), suggesting a shift in social acceptability of smoking in Indiana. More Hoosier adults strongly agreed that secondhand smoke is a serious problem. An increase to 38.5 percent in 2005 from the baseline findings of 30 percent in 2001. Also, a strong majority (88 percent) Hoosiers believe that tobacco companies should have not have the same rights as other industries to market their products.

Respondents who were aware of at least one ITPC billboard advertisement were 72 percent more likely to agree or strongly agree that smoking is not socially acceptable than those with no awareness of billboard advertisements. Adults who were aware of at least one ITPC radio advertisement were more than twice as likely to strongly agree they would feel comfortable telling people their age not to smoke, refuse cigarettes if someone offered them, and they would participate in community activities against tobacco use. In addition, Hoosier adults who were aware of at least one ITPC radio advertisement were 94 percent more likely to be knowledgeable about (strongly agree with) the dangers of tobacco use than those with no awareness of radio advertisements.

The overall awareness among youth of the ITPC public education campaign remained at similarly high levels as the year prior. In 2005, the findings yielded media-specific effects, with awareness of radio ads having a significant effect on social empowerment, and billboards and print ads affecting beliefs on dangers of tobacco use and social acceptability.

As was the case in the previous years, the public education campaign was successful in reaching Hoosier youth, with 80 percent of young people in Indiana confirming that they saw at least one ad, either on TV, on the radio, or in print. Confirmed awareness of the Voice component of the public education campaign showed the strongest relationship to attitude change. Several findings from the 2005 youth survey indicated that awareness of the Voice movement significantly influenced respondents' knowledge, attitudes, and beliefs. Youth with confirmed awareness of Voice were twice as likely to know the dangers of tobacco use. Youth with confirmed awareness of Voice were 13 times more likely to think that smoking is not cool or that smokers do not have more friends. Because the mass media component of the public education campaign did not target youth directly, this finding suggests that youth-specific approaches are needed to affect Hoosier youth attitudes and beliefs. For the most part, Hoosier youth hold strong anti-tobacco attitudes and know very well the dangers of tobacco use.

Community Program Evaluation

As mentioned in the **Community Programs** section, ITPC monitors the programs that occur at the local level. The activities occurring in the local communities are tracked to ensure the programs are executed properly and to assess the level of activity at the local level. Local coalitions enter their program reports through the ITPC website with a unique userID. Coalitions select from a set of activity types and answer a series of questions based on the activity type they select.

In addition to some results shared in the Community Programs section, we know that local coalitions have completed the following between SFY 2003 and SFY 2006[1]:

- Nearly 24,600 tobacco prevention and cessation activities have been conducted at the local level through ITPC grantees and staff
- ITPC partners raised awareness on tobacco control issues delivering a total of 4,500 presentations locally.
- Community members were trained to educate on tobacco control policies. A total of 1,800 training activities were recorded.
- More than 1,100 activities focusing on helping youth quit or educating them on the dangers of their smoking.

The Local Community-based and Minority-based Coalition Assessment was conducted in late 2005. The purpose was to assess local tobacco control infrastructure including coalition structure, staffing by local programs devoted to tobacco control programs, and implementation of programs. The survey also addressed local support for tobacco control among different sectors of the community. Data was collected from a web-based instrument that was administered to all local ITPC partners and supplemented by the review of the 2006-2007 grant applications from each coalition. A similar analysis was completed in 2003 and comparisons between years are made when applicable. Finally, key informant interviews with 46 coalition coordinators representing small and large (> 20 members); with varying levels community support (strong, medium and weak). The information was collected from this evaluation is intended to enable ITPC provide better technical assistance and training to its partners. AIR worked with the Indiana Minority Health Coalition in developing the interview guide and conducting the interviews. It was designed to collect details and supplemental information from an online survey. Overall, the interview guide focused on coalition's membership, community partnerships, funding, policy, program development and implementation, training, and general suggestions for support.

Highlights from this coalition assessment show that the size of the tobacco control coalitions grew compared to 2003. Based on the averages reported in 2005, health, community and youth organizations along with educational organizations are frequent members of the local coalitions. Notably, the business community is also represented on the coalitions. The data on type of organizations the local coalitions networked with shows untapped opportunities. Whereas we would expect networking with health orientated organizations such as health care providers, local health departments and substance abuse agencies and organizations working with youth (both educational institutions and youth service organizations), the data show little networking with civic organizations, grassroots organizations, faith based organizations and health insurance companies. These types of organizations offer an opportunity to expand the reach of tobacco control programs. In relationship to staffing issues, turnover was noted as an issue in 2005. This may be because in 2005, there were more opportunities for turnover than in 2003 when programs were still starting out. However, in contrast to 2003, fewer partners noted ability to offer job security as a factor. The number of full-time staff (FTE) devoted to tobacco control in each coalition dropped from 1.12 in 2003 to 0.65 in 2005.

The data also show a change in focus in coalition activities from 2003 to 2005. Although some changes like decrease in capacity building activities (e.g., coalition development and grassroots organization) may be attributed to the maturity of the program, the overall data show a narrowing of the type of activities conducted by the coalition.

Program funding is an important issue to the local programs, and in fact the majority of the respondents indicated that funding is not adequate. The most serious impact appears to be on the type of programs local partners would like to implement, but majority of respondents felt that funding levels are not adequate to implement planned programs, to address tobacco use in their community, to expand their coalition and to fill staff positions.

[1] Data as of August 2, 2006

The social and political climate did change somewhat from 2003 to 2005, with more coalitions reporting a greater degree of support from school systems and youth in 2005. More importantly, the reported support from the media has also increased in 2005. The support from other sectors remained similar, including that of elected officials who still appear to offer only moderate support and in about the quarter of the locations do not support tobacco control efforts.

Analysis of News Media

ITPC's mission is to change the cultural norms in Indiana around the issue of tobacco. One of the most effective ways to do that is through earned media coverage. AIR tracked information on news media coverage that is generated throughout the State.

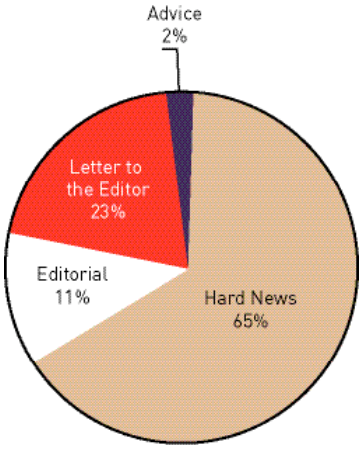
In SFY 2006, Indiana generated 3,249 newspaper clips, higher than SFY 2005 of 2,938 clips. Indiana has logged nearly 11,500 clips since SFY 2003. During SFY 2006:

- Approximately 10% of the stories had a national origin
- Thirty percent of the stories originating at the state level
- Nearly 60% began at the local level

This substantial number of stories occurring at the local level demonstrates how the local coalitions are working with the news outlets in their communities to keep local tobacco control in the news. The proportion of local stories has steadily increased each year.

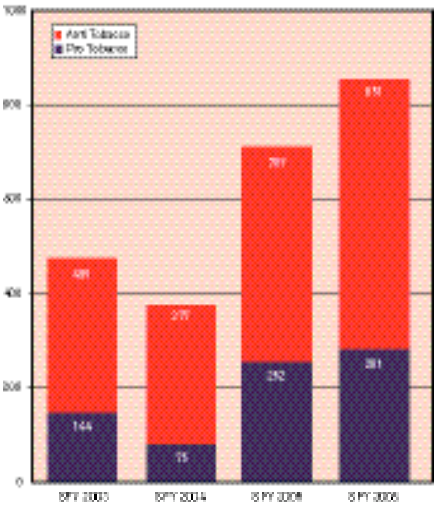
As illustrated in *Chart 38: Type of News Item Covered in Indiana Newspapers, SFY 2006,* a majority of the news stories were hard news. However, the percent of letters to the editor continue to increase from 20 percent in SFY 2005 to 23 percent in SFY 2006. This led to an overall increase in the opinion pieces SFY 2006, but the proportion of pro-tobacco (25%) to anti-tobacco (75%) opinion items did not change. The more frequent topics of news coverage were secondhand smoke, health consequences, coalition partner activities and cessation.

Chart 38: Type of News Item Covered in Indiana Newspapers, SFY 2006



Nearly seven out of ten news items were hard news articles with the remaining items opinion items.

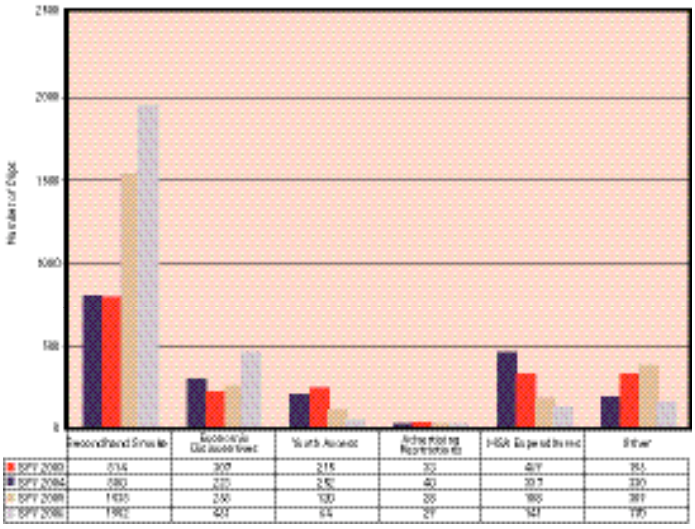
Chart 39: Slant of Opinion Items in Indiana News Media Coverage, SFY 2003-2006



Anti tobacco opinion items out number pro-tobacco items.

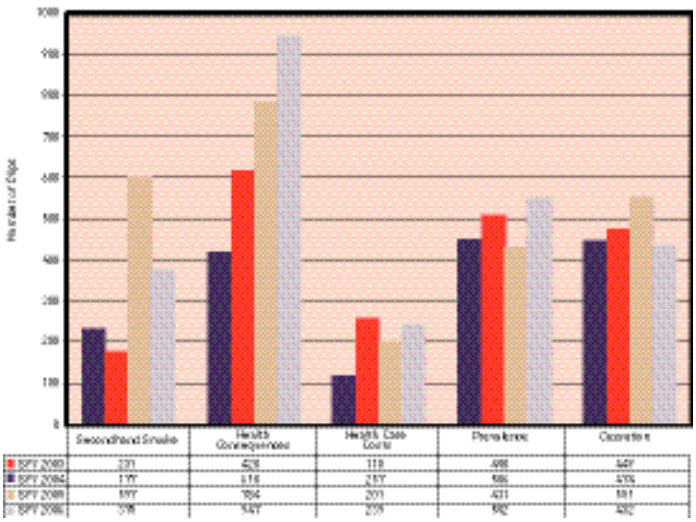
Newsclip data goes through March 31, 2006

Chart 40: Tobacco Control Policy Articles by Topic, SFY 2003-SFY 2006



The number of articles on specific tobacco c o ntrol policy. The most frequent topic includes secondhand smoke and continued to rise in 2006. Economic disincentives increase in 2006 mostly due to Governor Daniels tobacco tax increase proposal.

Chart 41: Articles on Health Consequences by Topic, SFY 2003-SFY 2006



The number of articles on health consequences of tobacco use. The most frequent topics include overall health consequences of smoking.

Also tracked is the number of articles by co u nty, as illustrated in Table 6: Number of news articles by county, SFY 2006. The number of clips per county varies from 0 to 283 clips. These data show the number of articles covered in newspapers based in a certain county; therefore a county's coalition may have been covered by a neighboring county's newspaper (the newspaper may serve more than one county). The following counties logged over 100 clips in SFY 2006 these include Bartholomew, Delaware, and Johnson. Marion and Tippecanoe counties have over 200 clips. All of these counties had a smoke free air ordinance campaign at some level during this past year.

Table 6: News Clips by County, SFY 2006

COUNTY	# Articles	COUNTY	# Articles
Adams	43	Madison	48
Allen	80	Marion	229
Bartholomew	134	Marshall	58
Benton	1	Martin	8
Blackford	8	Miami	17
Boone	20	Monroe	72
Brown	3	Montgomery	91
Carroll	2	Morgan	33
Cass	27	Newton	12
Clark	60	Noble	34
Clay	14	Ohio	0
Clinton	20	Orange	28
Crawford	0	Owen	13
Daviess	20	Parke	11
Dearborn	12	Perry	14
Decatur	13	Pike	1
DeKalb	64	Porter	87
Delaware	123	Posey	11
Dubois	48	Putnam	30
Elkhart	60	Randolph	29
Fayette	9	Ripley	7
Floyd	24	Rush	35
Fountain	12	St. Joseph	97
Franklin	7	Scott	8
Fulton	16	Shelby	46
Gibson	52	Spencer	5
Grant	39	Starke	2
Greene	23	Steuben	41
Hamilton	41	Sullivan	13
Hancock	69	Switzerland	4
Hendricks	19	Tippecanoe	283
Henry	35	Tipton	18
Howard	33	Union	2
Huntington	11	Vanderburgh	50
Jay	11	Vermillion	26
Jefferson	34	Vigo	72
Jennings	4	Wabash	14
Johnson	129	Warren	13
Knox	26	Warrick	2
Kosciusko	21	Washington	23
LaGrange	9	Wayne	27
Lake	84	Wells	24
LaPorte	45	White	15
Lawrence	28	Whitley	21

Dissemination of results

With the magnitude of information and data generated, ITPC is producing many reports to share these findings with others. These data are presented in a variety of media adapted for diverse audiences. ITPC, with the its evaluation and research coordinating center, present data to the ITPC Executive Board and Evaluation Committee, among other audiences and produced the following reports in SFY 2006:

- Indiana Media Tracking Survey: 2005 Comprehensive Report; Adult; August 2005
- Indiana Media Tracking Survey: 2005 Highlights Report; Youth; August 2005
- In addition, many fact sheets covering topics on adult and youth smoking, tobacco use among minorities and pregnant women, use of other tobacco products, secondhand smoke, the impact of tobacco business, have been developed and are available on the ITPC website at www.itpc.in.gov/research.asp

ITPC staff and partners frequently give presentations on its programs and the fundamentals of tobacco control throughout the State and to national organizations.

- **August 2005**
  - Many Voices One Vision Conference
    - "Partnering Within Your Community for a Healthy, Smokefree Environment", Anita Gaillard, Sandy Cummings, and Kelly Alley
    - "Some girls walk into a restaurant with an air monitor...", Miranda Spitznagle
  - National Association of Boards of Health Conference, "Partnering Within Your Community for a Healthy, Smokefree Environment", Anita Gaillard and Sandy Cummings
  - CDC/Office on Smoking and Health Media Network Conference Call "Media Tracking in Indiana" Miranda Spitznagle
- **October 2005**
  - CDC/Office on Smoking and Health Program Managers' Meeting "Sustaining Tobacco Control Funding" Karla S. Sneegas

- **November 2005**
  - American Public Health Association Annual Meeting- "Which adults are aware of anti-tobacco media messages", Terrell W. Zollinger, , Robert M. Saywell, Tess Weathers, Miranda Spitznagle, and Brittany S. Sutton

- **December 2005**
  - Warren, Fountain and Benton County office of Community Action Programs on "Tobacco Addiction and Reducing Tobacco Use in the Low Economic and Under - Educated Population", Karen O'Brien.

- **February 2006**
  - Indiana Middle Level Education Association-"Taming the Tobacco Beast" (tobacco free schools) Miranda Spitznagle and Jennifer Riley

ITPC Executive Director also serves in various leadership positions of major committees, including: Co-chair of the Lung and Other Tobacco Related Cancers Advisory Committee of the Indiana Cancer Consortium; Strategic Prevention Framework State Incentive Grant Advisory Board; Chair-Tobacco Control Committee of the Indiana Health Disparities CEO Roundtable; Advisory committee member for the American Legacy Foundation for EX Brand development; and a member of the Louisiana Scientific Advisory Committee.

Other ITPC staff serve on the following committees and boards: Finance advisory committee board member for the American Lung Association of Indiana; 2006 review of Research Proposals for Minnesota Partnership for Action Against Tobacco; member of the Indiana Joint Asthma Coalition (InJac) and the Public Education Committee; member of the Indiana Addiction Planning Council and the Prevention Committee; Robert Wood Johnson Fellow, Developing Leadership to Reduce Substance Abuse (2003-2006); Many Voices One Vision (MVOV) planning committee; member of advisory committees of th Data and the Lung and other tobacco related cancers for the Indiana Cancer Consortium; and member of the Surveillance and Evaluation work group of the State Prevention Framework-State Incentive Grant.

Fiscal Accountability

The ITPC Executive Board entered into a Memorandum of Understanding (MOU) with the State Board of Accounts (SBOA) in May 2002, to perform reviews of Tobacco Trust Fund grants that are awarded from ITPC to local entities. ITPC desires to ensure that local entities properly accounted for and spent the grant funds in accordance with grant requirements. ITPC determined that it was necessary to secure the services of a professional staff with the requisite expertise to undertake the reviews at the local level. From July 1, 2005 to June 30, 2006 the SBOA completed 57 monitoring engagements. All grant recipients have had at least two monitoring engagements to review the tobacco grant documents, with many have been engaged three times. Once grantees have the initial monitoring engagement, they are placed on the schedule to be reviewed annually until they are no longer in the program. ITPC's goal for the SBOA is to review all grant recipients' documents for compliance with contractual guidelines for the entire contract period and to conduct a final review upon the conclusion of the grant cycle period.

As a result of these reviews, the SBOA issues an agreed-upon procedures report to ITPC which provides ITPC the opportunity to target technical assistance efforts to the partners that demonstrate the greatest need, as well as, adhering to the overriding goals of ensuring funds are utilized effectively. The SBOA field auditors also provide training to partners and are available to answer entity specific questions regarding fiscal issues.

As a component of evaluation in the comprehensive tobacco control program, the ITPC Executive Board has chosen an innovative approach to monitoring its programs through a collaborative effort between two separate, yet distinct state agencies. This collaborative effort enhances and reinforces ITPC's sincere desire to demonstrate accountability to policymakers and other stakeholders.

Statewide Public Education Campaign

Purpose

The power of media and marketing to influence behavior and drive demand for products and services is well known. According to the 2003 Report from the Federal Trade Commission (FTC), the tobacco industry spent $15.4 billion on advertising, over $475 million in Indiana. The tobacco industry expenditures on advertising and marketing in 2005 increased 21 percent from the previous year. By comparison, the tobacco companies are spending 44 times what Indiana spends in tobacco prevention. Counter-marketing and public relations campaigns can break through the industry's clutter and communicate the truth about tobacco and the industry's deceptive marketing practices.

Indiana's statewide public education campaign is a combination of paid and earned media messages designed to counter pro-tobacco influences and increase pro-health messages and influences throughout the state. Counter-marketing consists of a wide range of efforts, including paid television, radio, billboard, and print counter-advertising at the state and local level; ethnic marketing; media advocacy and other public relations techniques using such tactics as news releases, news conferences, media outreach, media tours, editorial materials, featured stories, local events, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. Counter-marketing activities can promote smoking cessation and decrease the likelihood of initiation. They also can have a powerful influence on public support for tobacco control interventions and set a supportive climate for school and community efforts.

Indiana's Efforts

ITPC 's budget for all media expenditures for SFY 2006 was $1.7 million. This represents a decrease from $3.5 million in SFY 2005 resulting from a decline in overall funding. Per capita spending on the public education campaign had dropped from $0.86 in SFY 2004 to $0.54 in SFY 2005 and even further in SFY 2006 to $0.27. The CDC recommends that Indiana spend a minimum of $1.00 per capita for public education campaigns. The public education campaign targets both Indiana general population adults and youth, along with minority populations. The aim of the campaign is to educate the public about the dangers of tobacco use and secondhand smoke. Media serves to teach young and vulnerable consumers about deceptive tobacco industry marketing tactics. The campaign is working to change the social norms and acceptability of tobacco use in Indiana. Every county in the state continued to be reached by the statewide campaign.

Indiana's public awareness and media campaign provides critical support for all components of the Hoosier Model. ITPC and MZD Advertising, along with partners Promotus Advertising and Bingle Research, produced effective, award-winning campaigns that have high recall by Hoosiers. The Asher Agency, through contract with the State of Indiana, placed the media buys.

Whitelies.tv

Educating Hoosiers on the dangers associated with secondhand smoke remained a primary focus of ITPC's public education campaigns. The risks were brought to the forefront of health care issues following the release of the U.S. Surgeon General's report on secondhand smoke. Public education was key as many communities build foundations of support for smoke free air laws.

ITPC returned with a television campaign in the spring of 2006 for both the WhiteLies.tv and Voice brands. The WhiteLies.tv campaign maintained its focus on secondhand smoke, airing the previously-produced "Expert Does,", "SHS Is Dangerous" and "This Is Real."

With the launch of the pilot statewide quitline in March, ITPC partnered with Smokefree Indiana with a radio, newspaper and e-mail campaign that showed a positive impact on the number of calls coming into the call center through June. A coordinating newspaper ad was made available to ITPC's community-based and

minority-based partners for local use in spreading the message about the state's newest tool to combat tobacco addiction.

VOICE

Voice, Indiana's youth movement against tobacco, is a youth-led initiative exposing the deceptive marketing tactics of the tobacco industry. The youth communicate with their peers and work to fight back against the tobacco industry, rather than focus solely on the health message and health consequences of tobacco use.

A concerted effort was given this year to developing a year-long plan for building and maintaining momentum within the Voice movement. This development centered on three key events: the Indiana Teen Institute's (ITI) high school summer camp session, which focused on Voice; ACT 2005, the fall statewide youth summit incorporating a strong activism event; and, Drop Dead Day, a new initiative meant to encourage teens to take a stand against tobacco use and tobacco marketing in their community.

The ITI camp involved more than 220 Hoosier youth and Adult Allies gathering at Vincennes University in July for a week-long training on leadership, activism and the Voice movement in general. These and other tools were looped into sessions and hands-on activities to enable the participants to return to their communities empowered, willing and able to combat the tobacco industry.

With many of the youth who attended ITI camp participating as well as their peers from around the state, ACT 2005 commenced in Indianapolis in November as the second piece of the three-prong momentum-building approach. Nearly 300 teens and 50 adults converged for an intensive two-day, one-night stay. The youth created, coordinated and implemented a "drop", signifying the number of Hoosiers killed, or "dropping dead," each day by tobacco use. Summit sessions covered how to work with the media, how to plan and promote an event, and how to recruit participants. Youth were then equipped to go back into their local communities and create similar events that would culminate in a statewide "Drop Dead Day" in May. Adult Ally sessions focused on sharing ways to help the Voice movement develop as well as learning more about the tobacco industry and how it manipulates teens.

Two strong media components were looped into the ACT weekend. A Voice documentary, produced by Promotus Advertising, premiered during the opening ceremony of ACT and continues to be used as a resource for Voice recruitment at the local level. The video captures the sense of activism that is needed within Voice and gives viewers a glimpse of the variety of Voice activities and participants. The second media component was the filming of the new Voice ads "Drop" and "Raise". The ads focused on different aspects of the ACT activism event, the staged "drop", and featured Hoosier teens addressing the fact that they refuse to continue to be victims of the tobacco industry and its marketing tactics.

The third segment to the year-long effort was the successful implementation of Drop Dead Day. More than 500 youth in 45 cities from around the state participated in staged events during the first half of May. The emphasis was placed on conducting a "drop" in a highly visible community locale. As an extension of the "drop," many groups coordinated their activism with

other local events occurring at that time. Marketing and public relations assistance was provided to groups as they worked to draw attention to their respective activities.

Television and newspaper coverage captured the efforts of the youth groups, particularly in the Fort Wayne, Lafayette and Evansville markets. Promotional pieces included an activism guide outlining tips for creating a successful Drop Dead Day event (designed as a fold out piece that became a poster), the event logo and a t-shirt design.

Read more about Voice in the **Community Program** section beginning on page 76.

Expanding Our Brands Through Event Partnerships

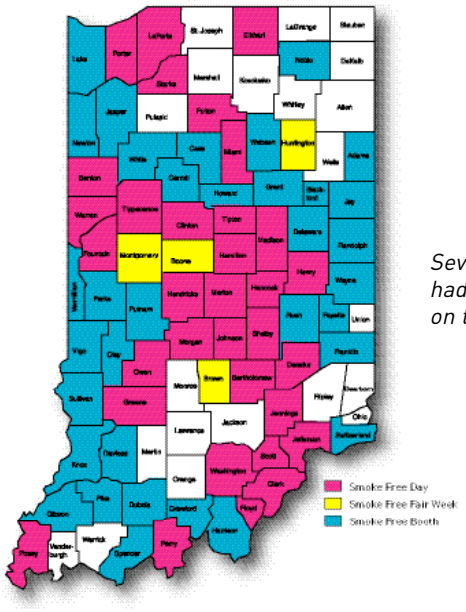
The partnerships created at the statewide, regional and local levels provided opportunities for extending ITPC's messaging. While participants may have been familiar with the WhiteLies.tv or Voice brands, the variety of activities organized over the past year garnered new exposure for both messages.

"Looking Forward – A Tobacco Free Future for Indiana", the Indiana Tobacco Control Partner Information X-Change held in March, was the cumulative effort of the Indiana State Partners Network, ITPC, Smokefree Indiana, and the Hoosier Faith and Health Coalition. While the event participants were already actively involved with tobacco control efforts, additional marketing and public relations efforts brought segments of the two-day event to the public's attention. These included the announcement of the inaugural Youth Advocate of the Year Award as well as the timing of the event to coincide with the launch of the Indianapolis, Greenfield and Carmel smoke free air ordinances.

Local community-based and minority-based coalition involvement with the American Cancer Society's Great American Smokeout in November also provided an outlet for local smoke free air messages. ITPC offered press releases, newspaper ads, flyers and public service announcements to its partners as they promoted their local events and cessation efforts. In August, 2005, the annual Tobacco Free Day took place as part of the fourth year of ITPC's sponsorship of the Indiana State Fair. The impact of this twelve-day partnership continues to improve each year, particularly as the Fairgrounds extends its non-smoking policy to new areas each year. Employees were provided with a training session, including information and updates on the no smoking policy. ITPC's message covered the grounds too as its informational brochures were displayed in fair venues year-round and banners were posted on Tobacco Free Day.

New and repeat visitors to the WhiteLies.tv booth were welcomed with a state map highlighting the varying degrees of tobacco-free school policies by county. Visitors were encouraged to sign the map as a show of support for the policies. Tobacco Free Day attendees were treated to a motocross show sponsored by Voice as well as an evening concert by the band Switchfoot. Voice youth participated in the daily parade and hosted a variety of activities to engage visitors at their booth. Many of the visitors were previously exposed to the Voice and/or WhiteLies.tv messages during the county fairs, when partners educated local crowds on tobacco use.

Figure 7: 2005 County Fairs-Smoke Free Days and Tobacco Control Coalition Booths



Seventy-two counties had a presence on the County Fairs.

Partners utilized ITPC's newspaper ads, public service announcements, banners, and marketing materials to extend the WhiteLies.tv brand locally through community events, fairs and festivals. The dangers of secondhand smoke continued to be the focus of this messaging, particularly through the use of local Tobacco Free or Smoke Free Day activities. In the summer of 2005, 36 of the 92 counties participated in their County Fairs with a Tobacco Free Day and another 32 counties had a booth at the fair, which allowed them to promote a tobacco free lifestyle. Four counties including Huntington, Montgomery, Boone, and Brown took that even further and were able to make the entire fair tobacco free!

Event sponsorship was of particular value in expanding the messages to ethnic audiences around the state. A primary example was the Indiana Black Expo's Summer Celebration in July. WhiteLies.tv and the Voice movement had a significant presence throughout the ten-day event. National comedienne Rene Hicks hosted the WhiteLies.tv free concert Sunday night, using the platform to speak about the dangers of smoking, secondhand smoke and how tobacco has affected her life. WhiteLies.tv had a large exhibit at the Indiana Black Expo information center, exhibit space within the health fair to distribute materials regarding the dangers of secondhand smoke and cessation, and inclusion in the Sunday morning church service, where more than 2,000 WhiteLies.tv church fans were shared with the congregation.

Teens attending the event were exposed to the Voice message through the exhibit space used to distribute posters, wristbands, and other materials that promoted Voice and recruited interested youth. A street marketing team and Voice youth conducted peer-to-peer and youth-to-adult marketing activities while being taped for the Voice documentary; these tactics included holding a shoe memorial inside of the exhibition hall to commemorate the 27 lives that are lost every day to tobacco-related diseases. Other activities included a Voice rally prior to the celebrity basketball game and crowd interaction during the Mike Jones hip-hop concert.

The 5th annual statewide conference on Hispanic/Latino issues in Indianapolis was another advantageous event. The goal of the conference was to bring together business and community leaders to address issues affecting the Hispanic/Latino population in Indiana. Youth in attendance spent the day learning how the tobacco industry has used Hollywood to market its product to youth and what Voice is doing to combat the problem.

Continuing to spread the anti-tobacco message within the urban and rural communities, ITPC utilized these activities for its Voice brand:

- The Circle City Classic Challenge of Champions Basketball Tournament in December. Promotional items were distributed to those in attendance and PA announcements regarding the harms of tobacco use were made on behalf of Voice.
- The DECA (Indiana) Statewide Conference in February. In its fourth year as a sponsor of the high school marketing association, Voice recruited more competitors in its palm card category – designed specifically for Indiana and Voice – where participants were judged on the creativity, originality and messaging of the promotional piece they designed for Voice. ITPC also provided judges for the conference.
- The NCAA Men's Basketball Final Four Championship weekend in April. A news release, in cooperation with the NCAA, regarding youth smoking messages, circulated as part of the NCAA Men's Basketball Championship in Indianapolis. Voice youth intermingled with the downtown crowd to share Voice palm cards and promotional items while Voice commercials aired in rotation with other sponsors on the large screen TVs.
- Campaign for Tobacco Free Kids' Kick Butts Day in April. ITPC provided a newspaper ad intended to highlight local Voice activities recognizing this national day. The ad encouraged community support and participation in local Kick Butts' Day activities, particularly in schools.
- The Jermaine O'Neal Super Shootout sponsorship in April. Voice youth produced a half-time Voice fashion show, a "drop dead" activism event on center court and additional on-site activities.

Media Advocacy

With a renewed emphasis on media advocacy, ITPC worked to keep the issue of tobacco control in the spotlight. National news, such as issuing of the Surgeon General's report on secondhand smoke, provided a strong foundation for ITPC and its partners to generate news. Additional tools, such as the weekly e-mailed Facts for Life statistic, monthly articles in the Indiana State Personnel Department newsletter and the ITPCommunity Connections newsletter allowed various audiences to keep abreast of tobacco control issues.

Hosting press conferences afforded ITPC the chance to speak directly with the media at various times throughout the year. In June, ITPC joined with the Indiana State Fair to discuss the news of the U.S. Surgeon General's report and the State Fair's decision to expand its smoke free policy to its Pfizer Family Fun Park. As the local communities rallied for passage of comprehensive smoking ordinances, ITPC assisted the respective local partners in conducting press conferences and achieving media outreach in an effort to educate the community on these important actions.

Additional press conferences occurred during the Partner Information X-Change to highlight a variety of stories, including the Westin Hotel chain's decision to create a 100% smoke free policy for its North American locations, the announcement of the Youth Advocate of the Year award winners and the recognition of the implementation of the Indianapolis, Carmel and Greenfield smoking bans. In January, ITPC joined state health officials in pledging support of the Governor's proposed tobacco tax increase. Another opportunity for supporting the state's comprehensive health care plans happened in July, when ITPC joined officials to launch the INShape Indiana initiative, of which quitting tobacco use is one component.

ITPC also issued a variety of news releases, opinion editorial pieces and letters to the editor on a variety of topics, including the following published articles:

- "Tobacco Control Officials Slam Decision to Use Indianapolis as Test Market for Smokeless Tobacco"
- "Indiana Tobacco Prevention Cessation Applauds Delphi Schools' Decision To Go Smoke Free"
- "U.S. Surgeon General's Report Affirms Secondhand Smoke as Public Health Threat. Indiana Recognized Nationally For Local Ordinance Success."
- "Indiana Tobacco Prevention Cessation Applauds Franklin Schools' Decision to Create Smoke-Free Campus"
- "Rural Indiana Healthcare Providers 'R.I.S.E.' Up Against Tobacco Use"
- "Evansville Hospital Officials Announce Support for Smoke-free Ordinance"
- "Indiana Releases Data on State of Hoosier Health"
- "IUPUI Campus to Become Tobacco Free; New Policy Promotes Health, Reflects Campus's Health/Life Sciences Emphasis"
- "Students Tell Tobacco to Drop Dead"
- "Smoky Rooms Full of Danger"
- "Reeve's Death Underscores Dangers Associated With Secondhand Smoke"
- "Pageant's Association with RJ Reynolds Reveals Unattractive Side to Respected Competition"
- "Indiana Launches Free Tobacco Quitline to Help Smokers Quit"
- "Hoosier Faith & Health Coalition Affirms Commitment to Smoke Free Lifestyle"
- "Comedienne Rene Hicks Offers 'Stand Up' Perspective on Secondhand Smoke"
- "Indiana Youth Advocate of the Year Awards Presented"
- "Indiana Tobacco Prevention and Cessation Honors Westin Hotels"
- "Statewide Conference Focuses Attention on Tobacco Cessation. Hundreds of Attendees Descend on Indianapolis, Celebrate Adoption of Smoke-Free Policies in Four Indiana Communities."
- "Health Officials and Tobacco Prevention Advocates Support Cigarette Tax Increase"
- "Indiana's Fourth Annual Tobacco Free Day at the Indiana State Fair"

Findings

Advertisement awareness is the first major step in an effective media campaign because the audience must be aware of advertisements to be influenced by them. Findings from other state and national campaigns suggest that advertisement awareness increases anti-tobacco knowledge, attitudes, and beliefs, leading to reductions in cigarette smoking. Results from the ITPC media tracking surveys conducted annually since 2001 indicate that the media campaign has had a positive influence on youth and adult knowledge, attitudes, and beliefs each year. The media campaign messages coupled with the community efforts of local and statewide youth serving organizations, prevention and cessation programs, and Voice will continue to change social norms around tobacco use.

Data from July, 2005 show that the overall awareness of the campaign remained at levels similar to previous years, despite substantial cuts in the advertisement budget. However, the public education campaign was only visible during the spring of 2006, and the impact of this gap will not be known until the next data collection in late 2006.

In 2005, three out of four Hoosier adults (73.2%) can recall at least one ITPC anti-tobacco advertisement. Sixty-nine percent (69%) of adults could recall at least one television ad. As was the case in the previous years, the public education campaign was successful in reaching Hoosier youth, with 80 percent of young people in Indiana confirming that they saw at least one ad, either on TV, on the radio, or in print. Confirmed awareness of the VOICE component of the public education campaign showed the strongest relationship to attitude change. Additional results from the media tracking surveys can be found in the **Evaluation and Surveillance** section beginning on page 88.

News Media

ITPC's mission is to change the cultural norms in Indiana around the issue of tobacco. One the most effective ways to do that is through earned media coverage. Since May 2002, Indiana generated nearly 11,500 clips; with a substantial number of stories occurring at the local level demonstrates how the local coalitions are working with the news outlets in their communities to keep local tobacco control in the news. A majority of the news stories was hard news. The more frequent topics of news coverage were coalition partner activities, clean indoor air, and health consequences. See "Analysis of News Media" in the **Evaluation** section.

Enforcement

Purpose

Enforcement of tobacco laws can deter violators and sends a message that community leaders believe these policies are important for protecting Indiana's youth. Youth access laws give youth an environment in which tobacco is unacceptable. Youth who do not use tobacco products by the age of 19 are less likely to start later in life. Enforcement of Indiana's tobacco laws deters youth from trying to obtain tobacco products and retailers from illegally selling tobacco products to minors.

Indiana's Efforts

In SFY 2006, ITPC continued its Memorandum of Understanding (MOU) with the Indiana Alcohol and Tobacco Commission (ATC) to investigate and enforce Indiana's tobacco laws with an annual budget of $500,000.

After more than five years of activity, enforcement of Indiana's tobacco laws has become a priority for the law enforcement community due to the efforts of ATC. The MOU has continued to:

- Provide additional 13 state excise officers and one administrative support staff;
- Make resources available for training law enforcement officers on the investigation and enforcement of Indiana's tobacco laws
- Allow ATC to contract with various local law enforcement agencies and/or officers to assist in enforcing those laws.

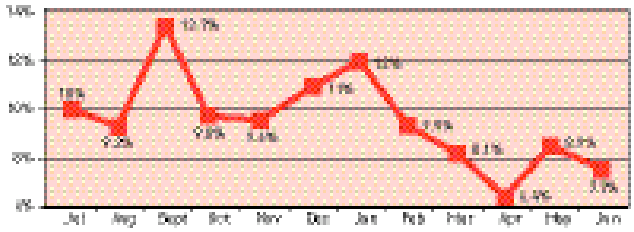
Throughout SFY 2006, 13 Tobacco Retailer Inspection Program (TRIP) officers were out in the field conducting inspections. In addition, Excise officers worked throughout the State reporting tobacco law violations. Through the year at the Law Enforcement Academy over 1500 law enforcement officers received tobacco laws training. This training includes review of all Indiana tobacco laws including signage, retail sales including implications to the clerk and establishment, possession by a minor and vending machines restrictions.

ATC is also responsible for conducting training for retail owners and clerks to prevent the sales of tobacco to minors. ATC has performed more than 550 retailer trainings reaching over 13,000 people from July 2005 to June 2006. As part of these trainings and in other opportunities, ATC has produced and distributed written materials relating to the sale of tobacco products to minors and Indiana's tobacco laws. The ATC is out at various events with literature regarding the tobacco laws, required signage and other items promoting the "ID on Demand" message. ATC also is encouraging use of the statewide toll free number to report retailers and vendors who violate Indiana's tobacco laws. Citizens who witness illegal sales of tobacco products to minors can call 1-866-2STOPEM. All calls are confidential. There were 11 reported calls in SFY 2006.

Findings

The focus of ATC's work is conducting random inspections of tobacco retailers throughout Indiana. The MOU with ITPC outlined a minimum of 375 tobacco retail inspections to be performed each month. Focusing on the efforts in SFY 2006, TRIP officers conducted more than 7,500 inspections of retail tobacco outlets, averaging over 625 inspections per month. TRIP enforcement activities have resulted in sales rates to youth at an average of 10 percent for SFY 2006. Throughout SFY 2003 to SFY 2006, the non-compliance rate of Indiana's tobacco retailers consistently remained below 20 percent. The national Synar study requires Indiana to have a noncompliance rate below 20 percent or risk losing millions of dollars for substance abuse treatment through the Division of Mental Health and Addiction.

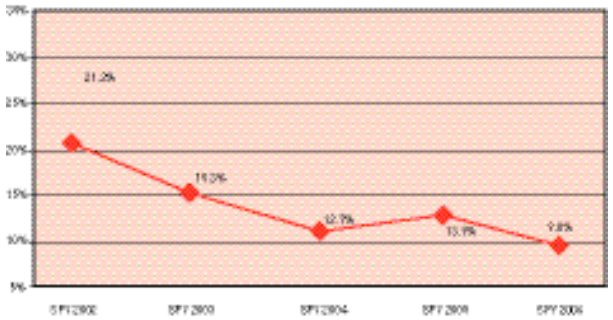
Chart 42: Noncompliance Rate of Indiana Tobacco Retailers Inspected by TRIP, SFY 2006



The average noncompliance rate from July 2005 to June 2006 was 9.8%.

From October 2001, through June 2006, TRIP officers conducted over 36,000 inspections of retail tobacco outlets. The annual noncompliance rate has decreased from 21 percent in SFY 2002 to 10 percent in SFY 2006.

Chart 43: Noncompliance Rate of Indiana Tobacco Retailers Inspected by TRIP, SFY 2002 to SFY 2006



The annual noncompliance rate has declined since SFY 2002 and remained stable in SFY 2004-2005 and declined further in SFY 2006.

Beginning in May 2002, results of these inspections are posted on the ATC website (**www.in.gov/atc/isep/TriplOR.htm**) as a way to promote to the public those retailers who violate and those retailers who consistently comply with Indiana's tobacco laws.

Other data supporting the lower noncompliance rates comes from the Indiana YTS. In 2000, approximately 30 percent of current high school smokers trying to buy cigarettes were refused due to age. This percentage increased significantly to nearly 44 percent in 2004. While this can be improved, this is an indication that fewer youth are obtaining tobacco in retail establishments. Difficulty in obtaining cigarettes may be a barrier to smoking behavior encouraging some smokers to quit. If obtaining cigarettes is likely to involve the embarrassment of being asked for proof of age, and having to face possible legal consequences, it may simply be seen as not worth the effort. It also sends a strong message that smoking by youth is not acceptable.

In addition to the duties covered in the MOU, ATC has worked with ITPC to conduct regional training for ITPC community-based and minority-based partners. Some ITPC community partners have included local enforcement of tobacco laws in their coalition's plans and ATC is working closely with them to ensure the coalitions have proper training and resources to conduct these retailer compliance checks in their communities and to prosecute those noncompliant retailers through State and local systems.

Administration/ Management

Purpose

Past experience in Indiana and from other states who conduct comprehensive tobacco control programs has shown that an effective tobacco control program requires a strong management structure. Experience also shows the importance of having the entire program components coordinated and working together. Administration of a comprehensive program involves coordination of multiple state agencies (e.g., health, education, and law enforcement) and levels of local government, as well as numerous health-related voluntaries, coalitions, and community groups, program management. Furthermore, coordinating and integrating major statewide programs, such as counter-marketing campaigns with local program efforts require adequate staffing and communication systems. State agencies need sufficient contract administration staff to provide oversight of fiscal and program activities. Funding a large number of statewide and local partners requires a well-designed request for proposals and grant application processes, a well-managed review system and hands-on project management. Administration and management activities include the following:

- Recruiting and developing qualified and diverse technical, program, and administrative staff.
- Awarding and monitoring program contracts and grants, coordinating implementation across program areas, and assessing program performance.
- Creating an effective internal and external communication system.
- Developing a sound fiscal management system.
- Providing support through training and technical assistance.

Indiana's Efforts

ITPC is administering 110 grants and contracts with an annual overall budget of $10.8 million. The CDC's Best Practices for Comprehensive Tobacco Control Programs recommends that Indiana spend 5 percent of our total budget on administrative expenses. Indiana's total budget for SFY 2005 and SFY 2006 came to a total of $27.9 million. During SFY 2006, ITPC operated with a carryover of $5.0 million from previous years. As the annual overall budget has been reduced from an average appropriation of $32.5 million to $10.8 million, it has been increasingly difficult to stay within the CDC's recommendation to limit spending on Administration and Management to 5 percent of total budget dollars. Insightful management has guided ITPC through the budget reductions, keeping this expense at less than 5 percent of our total budget as recommended by the CDC and maintaining the 26 percent administrative and management expense budget reduction proposed in SFY 2004.

ITPC currently has 13 employees and 7 vacant positions. Some of the responsibilities of these vacant positions are handled by ITPC staff and contracts. The CFO staff position has taken on additional human resources duties previously handled by the HR/Management Director. In 2004, the ITPC board decided not to fill the Deputy Director position. Duties of the Media/Communications director are handled through the media/public relations contract. The senior systems analyst responsibilities are covered through a memorandum of understanding with the Indiana Office of Technology (IOT). (See organizational chart on page 67).

In order to manage the large number of grants ITPC established a Memorandum of Understanding with the State Board of Accounts (SBOA) to assist with the fiscal monitoring of each grant. The SBOA conducts an onsite review of each grantee with reports to be filed with ITPC. From July 1, 2005 to June 30, 2006, the SBOA completed 57 monitoring engagements. Most grant recipients have been subjected to a monitoring engagement during each 12 month period, the purpose of which is to review the tobacco grant documents. ITPC's goal for the

SBOA is to review all grant recipients' documents for compliance with contractual guidelines for the entire contract period and to conduct a final review upon the conclusion of the grant cycle period. During SFY 2006, the SBOA conducted final monitoring engagements on most of the contracts as we complete the four-year contracts ending on June 30, 2005. Those contracts were initially two year contracts which were renewed for an additional 18 months. The final reviews have begun on contracts ending June 30, 2005 and simultaneous reviews are conducted on the current grant contracts with grant cycles which run July 1, 2005 and ends on June 30, 2007.

Through IC 4-12-4, ITPC was charged with coordinating tobacco prevention and control efforts throughout the State. ITPC continues to work with many state agencies and organizations to efficiently provide services and to pool resources to combat this huge problem in Indiana. Beginning in January 2006, Governor Daniels established policy that requires all downtown Indianapolis State Government Facilities and grounds to be smokefree. This policy is enforced by the Indiana Department of Administration, Division of Facilities Management. With the assistance of the 104 established partners and coalitions, ITPC has coordinated smoking cessation services in numerous State of Indiana facilities around the state for employees upon request. There is an on-going smoking cessation class offered in the Indiana Government Center year round.

INDIANA TOBACCO PREVENTION AND CESSATION

STATEMENT OF RECEIPTS, DISBURSEMENTS AND CASH AND INVESTMENT BALANCES

For the Period Ended June 30, 2006

Cash and Investments, July 1, 2005		**$5,005,731**
Receipts:		
Interest on Investments	239,856	
Appropriation from Master Settlement Fund	10,092,344	
Local Grant Dollars Returned from FY04-05 Grant Cycle	1,571,272	
Honorarium	750	
Total Receipts		**11,904,222**
Disbursements:		
Advertising Expenditures		1,156,402
Enforcement of Youth Access - Alcohol Tobacco Commission		500,000
Community Grants		4,052,899
Minority Grants		1,447,031
Statewide Grants		208,300
Chronic Disease Collaborative Project		358,482
Voice		360,000
Special Opportunity Grants to Local Communities		89,210
Training, Technical Assistance, and Educational Materials to Grantees		156,833
Program Evaluation - American Institute for Research, St Bd of Accts, Policy, YTS		755,163
Administration and Management		884,058
Total Disbursements		**9,968,378**
Excess of Receipts over (under) Disbursements		**1,935,845**
Fund Balance July 1, 2005		**$5,005,731**
Cash and Investments, June 30, 2006		**$6,941,576**

Notes to the Annual Financial Report

June 30, 2006

Note 1. Summary of Significant Accounting Policies

A. Introduction

The Indiana Tobacco Prevention and Cessation Agency is part of the executive branch of government. As an agent of the Indiana Tobacco Use Prevention and Cessation Executive Board, the Agency is responsible for expending funds and making grants to significantly improve the health of the citizens of the State of Indiana by overseeing the development of tobacco use prevention and cessation programs throughout the State.

B. Reporting Entity

The Indiana Tobacco Prevention and Cessation Agency was created by IC 4-12-4, to establish policies, procedures, standards, and criteria necessary to carry out the duties of the staff of the executive board. Funds needed to operate the Agency are obtained through appropriation by the General Assembly from the Master Settlement Agreement IC 24-3-3-6. The Agency received its initial funding during fiscal year 2000-2001, with a $35 million dollar appropriation. Additional appropriations made to the Agency include $5 million in 2001-2002, and $25 m i llion in 2002-2003, of which only $15 million was actually received, and #21.6 million in 2003-2004 in total for the two year budget cycle, FY 04 & FY 05. The annual appropriations for the periods of 2005-2006 and 2006-2007 total $21.6 million, with a mandated 7% reserve.

Note 2. Deposits and Investments

Deposits, made in accordance with IC 5-13, with financial institutions in the State of Indiana at year-end were entirely insured by the Federal Depository Insurance Corporation or by the Indiana Public Deposit Insurance Fund. This includes any deposit accounts issued or offered by a qualifying financial institution. The Treasurer of State shall invest money in the fund not currently needed to meet the obligations of the fund.

Note 3. Net Appropriation

Appropriations presented are net of reversions to the Indiana Tobacco Use Prevention and Cessation Trust Fund at year-end.

INDIANA TOBACCO USE PREVENTION AND CESSATION EXECUTIVE BOARD

ANNUAL BUDGET 2006-2007

Budget Item	Fiscal Year 2006	% of Budget	FY 06 Encumbrances to be paid in FY07		Fiscal Year 2007	% of Budget
* **STATEWIDE PUBLIC EDUCATION CAMPAIGN**	**$1,700,000**	**14%**	**$600,848**		**$1,700,000**	**14%**
* **ENFORCEMENT OF YOUTH ACCESS - ATC**	**$500,000**	**4%**	**$0**		**$500,000**	**4%**
* **COMMUNITY BASED PROGRAMS**	**$8,225,511**	**66%**		**2**	**$8,225,511**	**66%**
1. Local Community Based Partnerships	$4,456,228		**$199,614**		$4,456,228	
2. Minority Based Partnerships	$1,640,000		**$162,500**		$1,640,000	
3. Statewide Grants	$500,000		**$500,000**		$500,000	
4. Chronic Disease Collaborative Project	$500,000				$500,000	
5. Voice Hubs	$360,000		**$0**		$360,000	
6. Special Opportunity Grants to Local Communities	$535,636		**$23,662**	4	$535,636	
7. Training & Technical Assistance	$233,647		**$1,000**		$233,647	
* **EVALUATION (AIR & SBOA)**	**$900,000**	**7%**	**$886,320**		**$900,000**	**7%**
* **ADMINISTRATION/ MANAGEMENT**	**$1,200,000**	**10%**			**$1,200,000**	**10%**
TOTALS	**$12,525,511**	**100%**	**$2,373,944**		**$12,525,511**	**100%**

Budget for FY 2006 & 2007 Approved at the August 18, 2005 Executive Board Meeting, amended November 11, 2005 and updated August 22, 2006 for grant dollars returned as of June 30, 2006.

Fiscal Year 2007 includes rollover dollars of $6.9 million. IC 4-12-4-10 states that dollars, including interest, in the Tobacco Prevention and Cessation Trust Fund do not revert to the General Fund or any other fund at the end of the fiscal year and remain available for use by the ITPC Executive Board.

The 7% reserve mandated on June 23, 2005, by order of the State Budget Agency, still remains in effect. Reserves are not allocated to agencies, therefore they cannot be budgeted or expended until the reserve is released.

NOTES

Sources

1 Centers for Disease Control and Prevention, 2002
2 Centers for Disease Control and Prevention. Tobacco Control Data Highlights 2005. Atlanta, GA: U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
3 U.S. Environmental Protection Agency (1989). Indoor Air Facts: Environmental Tobacco Smoke; Centers for Disease Control and Prevention.
4 The National Toxicology Program
5 U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
6 Taylor, A., Johnson, D. & Kazemi, H., "Environmental Tobacco Smoke and Cardiovascular Disease," Circulation, 1992; 86: 699-702.
7 http://www.tobaccofreekids.org/reports/settlements/toll.php?StateID=IN
8 Misra, D.P., and R. Nguyen. 1999. "Environmental Tobacco Smoke and Low Birth Weight: A Hazard in the Workplace?" Environmental Health Perspectives 107(Suppl 6):897-904.
9 Secondhand Smoke Tearing Families Apart. The American Legacy Foundation. June 2004.
10 U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
11 Centers for Disease Control and Prevention; Department of Health and Human Services, "Second National Report on Human Exposure to Environmental Chemicals," National Center for Environmental Health (NCEH Pub. No. 02-0716) January 2003. ;Centers for Disease Control; Department of Health and Human Services, "Facts about Secondhand Smoke," Updated: September 2003.
12 "Disparities in Smoke Free Work Policies Among Food Service Workers" Journal of Occupation and Environmental Medicine- April 2004
13 2000-2001 Current Population Survey-Tobacco Use Supplement, Indiana state estimates.
14 The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. 2006; Centers for Disease Control and Prevention,"State-specific prevalence of cigarette smoking among adults, and children's and adolescent'sexposure to environmental tobacco smoke-United States 1996", MMWR 46(44).
15 2004 Indiana Youth Tobacco Survey
16 The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. 2006
17 Schick, S and Glantz S. "Philip Morris toxicological experiments with fresh sidestream smoke: more toxic than mainstream smoke," Tobacco Control 2005; 14:396-404
18 Barnoya, J.; Glantz, S.A., "Cardiovascular effects of secondhand smoke: nearly as large as smoking," Circulation 111(20): 2684-2698, May 24, 2005.
19 The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. 2006
20 National Cancer Institute. Health Effects of Exposure to Environment Tobacco Smoke. Smoking and Tobacco Control Monograph No. 10 Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; 1999. NIH Pub. No. 99-4645.
21 Grant, S.G., "Qualitatively and quantitatively similar effects of active and passive maternal tobacco smoke exposure on in utero mutagenesis at the HPRT locus," BMC Pediatrics, 2005, 5:20.
22 National Cancer Institute, National Institute of Health
23 Glantz S.A. Tobacco Biology and Politics: An Expose of Fraud and Deception. 1999.
24 Committee on the Assessment of Asthma and Indoor Air. 2000. Clearing the Air: Asthma and Indoor Air Exposures. Division of Health Promotion and Disease Prevention, Institute of Medicine, Chapter 7. ; Gold,D.R. 2000. "Environmental Tobacco Smoke, Indoor Allergens, and Childhood Asthma." Environmental Health Perspectives 108(suppl 4):643-651.
25 Yu-Fhen, Li. et al., "Maternal and Grandmaternal Smoking Pattern Are Associated With Early Childhood Asthma," Chest, 127(4): 1232, 2005.
26 U.S. Environmental Protection Agency. Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. EPA/600/6-90/006B, 1992.
27 Secondhand Smoke Tearing Families Apart. The American Legacy Foundation. June 2004.
29 Gilliland, F.D.; Berhane, K.; Islam, T.; Wenten, M.; Rappaport,E.; Avol, E.; Gauderman, W.J.; McConnell, R.; Peters, J.M., "Environmental tobacco smoke and absenteeism related to respiratory illness in school children," American Journal of Epidemiology 157(1): 861-869, May 15, 2003.
30 DiFranza, J.R., and R.A. Lew. 1996. "Morbidity and Mortality in Children Associated with the Use of Tobacco Products by Other People." Pediatrics 97(4):560-568.; Secondhand Smoke Tearing Families Apart. The American Legacy Foundation. June 2004.
31 DiFranza, J.R., and R.A. Lew. 1996. "Morbidity and Mortality in Children Associated with the Use of Tobacco Products by Other People." Pediatrics 97(4):560-568.; Secondhand Smoke Tearing Families Apart. The American Legacy Foundation. June 2004.
32 Yolton, K. et al., "Exposure to Environmental Tobacco Smoke and Cognitive abilities of U.S. Children and Adolescents," Environmental Health Perspectives, 113(1): 98-103
33 International Agency for Research on Cancer, Volume 83: Tobacco Smoke and Involuntary Smoking Summary of Data Reported and Evaluation, June 2002.
35 Sargent RP, Shepard RM, Glantz SA. Reduced incidence of admission for myocardial infraction associate with public smoking ban: before and after study. BMJ 2004; 328: 977-80.
36 Pechacek, Terry F.; Babb, Stephen, "Commentary: How acute and reversible are the cardiovascular risks of secondhand smoke?" British Medical Journal 328: 980-983, April 24, 2004.
37 Barnoya J and Glantz SA. "Cardiovascular effects of secondhand smoke-nearly as large as smoking", Circulation, 2005;111:2684-98.

38 Whincup, P.H.; Gilg, J.A.; Emberson, J.R.; Jarvis, M.J.; Feyerabend, C.; Bryant, M.W.; Cook, D.C. "Passive smoking risk of coronary heart disease and stroke prospective study with cotinine measurement." British Medical Journal, doi: 10.1136/bmj.38146.427188.55 (published 30 June 2004).

39 U.S. Public Health Service's National Toxicology Program issued its 10th Report on Carcinogens. Research Triangle Park, NC: U.S. Department of Health and Human Services, Public Health Service, National Toxicology Program, December 2002.

40 The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. 2006

41 California Air Resources Board (ARB) Scientific Review Panel (SRP) "Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Containment - June 24, 2005."

42 California Air Resources Board (ARB) Scientific Review Panel (SRP) "Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Containment - June 24, 2005."

43 Zollinger, Saywell, Overgaard, and Holloway. "The Economic Impact of Secondhand Smoke on the Health of Residents and Employee Smoking on Business Costs in Marion County, Indiana for 2000." A Report for the Marion County Health Department February 2002.

44 Berman K. "Firms hope smoking bans will trim health costs". Business Insurance. October 12, 1987;21(41):16-17

45 Halpern MT et al. " Impact of smoking status on workplace absenteeism and productivity". Tobacco Control 10(3): 233-38, September 2001.

46 Musich S , Napier D, Edington DW. "The association of health risks with workers' compensation costs". Journal of Occupational and Environmental Medicine. 43(6): 534-41, June 2001

47 July 2001, Journal of Occupational and Environmental Medicine; Study of over 3000 Xerox corp. employees

48 Kristein MM. American Health Foundation. "How much can business expect to profit from smoking cessation?" Preventive Medicine 1983; 12:358-381.

49 Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs --- United States, 1995-1999, US Public Health Service, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly, April 12, 2002 / 51(14);300-3

50 Alamar, B.; Glantz, SA "Smoke-Free Ordinances Increase Restaurant Profit and Value." Contemporary Economic Policy, 22 (4), October 2004, 520-525.

51 "The dollars (and sense) benefits of having a smoke-free workplace," Michigan Department of Community Health, [2000].

52 Dr. William L. Weis, Associate Professor of Business Administration, Albert School of Business, Seattle University

53 Centers for Disease Control and Prevention. MMWR — Annual Smoking–Attributable Mortality, Years of Potential Life Lost, and Productivity Losses — United States, 1997–2001. MMWR Highlights. 1 July 2005. Vol. 54. No. 25.

54 CTFK, "Indiana cigarette tax increases estimated new revenues, cost savings, and other benefits and effects based on CDC Sustaining State Programs for Tobacco Control: Data Highlights 2004.

55 The Cost of Caring: Key Drivers in Hoosier Healthcare Spending, February 2004. Indiana Hospital and Health Association. PricewaterhouseCoopers.

56 Campaign for Tobacco Free Kids Fact Sheet, "Increasing State Smoking-caused Medicaid Costs and Future Medicaid Savings from a 25% Reduction to State Smoking Rates", April 15, 2004.

57 Smokers have lifetime health costs that are $12,000 higher than nonsmokers, despite the fact that the smokers, on average, die younger than nonsmokers. Data from Hodgsen, " Cigarette Smoking and Lifetime Medical Expenditures, The Millbank Quarterly provides data in estimating the costs of a smoker to the State's Medicaid program ($1950). This data is from 1992 and is not adjusted for inflation and is a conservative figure. These include public and private health care costs.; Number of Medicaid enrollees in Indiana (SFY 2003) 707,168. http://www.cms.hhs.gov/medicaid/managedcare/mcsten03.pdf

58 Warner KE. Cost effectiveness of smoking-cessation therapies. Interpretation of the evidence and implications for coverage. Pharmacoeconomics 1997;11(6):538–49. ;Cummings SR, Rubin SM, Oster G. The cost-effectiveness of counseling smokers to quit. Journal of the American Medical Association 1989;261(1):75–79. ;Coffield AB, Maciosek MV, McGinnis JM, et al.. Priorities among recommended clinical preventive services. American Journal of Preventive Medicine 2001;21(1):1–9.

59 Schauffler HH, McMenamin S, Olsen K, Boyce-Smith G, Rideout JA, Kamil J. Variations in treatment benefits influence smoking cessation: results of a randomized controlled trial. Tobacco Control 2001;10:175–80. ; Curry SJ, Grothaus MA, McAfee T, Pabiniak C. Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. New England Journal of Medicine 1998; 339(10):673–79.

60 Centers for Disease Control and Prevention. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States, 1995_1999. Morbidity and Mortality Weekly Report 2002;51(14); 300–03.

61 Warner, K., et.al. cited in Business & Health, Vol. 15, #8, Supplement A, Medical Economics, Montvale, NJ.

62 National Business Group on Health, Issue Brief, Volume I, Number 5)

63 Centers for Disease Control and Prevention, Office on Smoking and Health, "African Americans and Tobacco", Fact Sheet

64 Centers for Disease Control and Prevention, Office on Smoking and Health, "African Americans and Tobacco", Fact Sheet. Centers for Disease Control and Prevention. At-A-Glance. Tobacco Use Among U.S. Racial/Ethnic Minority Groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics, Atlanta: CDC, 1998.

65 2005 BRFSS, all states median.

66 U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Latinos: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998

67 2002 Indiana Adult Tobacco Survey.

68 2004 Indiana Youth Tobacco Survey.

69 Centers for Disease Control and Prevention, Office on Smoking and Health, "African Americans and Tobacco", Fact Sheet U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998.

70 Indiana Cancer Facts and Figures 2003.

71 Leistikow B. "Lung cancer death rates as an index of smoke exposures: validation against black male-non lung cancer death rates, 1969-2000. Preventive Medicine 38 (2004) 511-515; and August 2005.
72 U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Latinos: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998
75 Glode WF. RJR puts on the Ritz, PM goes to Rio. Advertising Age 1985 (56.2):1, 78; Leviten P. Manufacturers send changing smoking signals. Supermarket Business 1985 (40.12):39-43; and Walters DKH. Cigarettes: Makers Aim at Special Niches to Boost Sales. Los Angeles Times 1985 Sept 15; Business Section:1 (col 3).
76 U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Latinos: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998.
77 U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Latinos: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998.
78 U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups — African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998.
79 1999-2003 Indiana birth certificate data. Indiana State Department of Health.
80 Martin, J.A., et al. December 17, 2003. "Births: Final Data for 2002." National Vital Statistics Reports 52(10):1-113. Hyattsville, MD: National Center for Health Statistics. ; U.S. Department of Health and Human Services (USDHHS). 2000. Healthy People 2010, 2nd Ed. U.S. Government Printing Office: Washington, DC.
81 Ventura, S.J. 2003. "Trends and Variations in Smoking during Pregnancy and Low Birth Weight: Evidence from the Birth Certificate, 1990-2000." Pediatrics 111(5 Part 2):1176-1180.
82 DHHS. 2001. Women and Smoking: A Report of the Surgeon General. U.S. Department of Health and Human Services, Public Health Service: Rockville, MD, Office of the Surgeon General, U.S. Government Printing Office: Washington DC. ; Gavin, N.I., et al. September 2001. Review and Meta-Analysis of the Evidence on the Impact of Smoking on Perinatal Conditions Built into SAMMEC II. Final Report to the National Center for Chronic Disease Prevention and Health Promotion. Research Triangle Park: Research Triangle Institute.
83 2004 National Youth Tobacco Survey. NYTS is a comparable instrument conducted nationally by the American Legacy Foundation.
84 2004 Indiana Youth Tobacco Survey; 2005 Indiana Youth Risk Behavior Survey
85 Middle school frequent user was 100% due to one observation.
86 2004 Indiana Adult Tobacco Survey
87 1999 BRFSS
88 2004 Indiana Adult Tobacco Survey
89 National Cancer Institute. Smokeless Tobacco and Cancer. www.smokefree.gov/Docs2/SmokelessTobacco_Q&A.pdf Accessed 6/29/2006
90 CDC. "Oral Cancer: Deadly to Ignore" Accessed 8/31.06.
91 U.S. Department of Health and Human Services. Preventing Tobacco Use Among Young People: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.
92 National Cancer Institute. Cigars: Health Effects and Trends. Smoking and Tobacco Control Monograph No. 9. Bethesda, MD: National Institutes of Health, National Cancer Institute; 1998. NIH Pub. No. 98–4302.
93 National Cancer Institute. Cigars: Health Effects and Trends. Smoking and Tobacco Control Monograph No. 9. Bethesda, MD: National Institutes of Health, National Cancer Institute; 1998. NIH Pub. No. 98–4302.
94 CDC. Youth Risk Behavior Surveillance — United States, 2003. CDC Surveillance Summaries 2004;53(SS-2):1–96.
95 2004 Indiana Youth Tobacco Survey
96 National Cancer Institute. Cigars: Health Effects and Trends. Smoking and Tobacco Control Monograph No. 9. Bethesda, MD: National Institutes of Health, National Cancer Institute; 1998. NIH Pub. No. 98–4302.
97 Iribarren C, Tekawa I, Sidney S, Friedman G. Effect of cigar smoking on the risk of cardiovascular disease, chronic obstructive pulmonary disease, and cancer in men. New England Journal of Medicine 1999;340:1773–1780.
98 National Cancer Institute. Questions and answers about cigar smoking and cancer.
99 CDC. Bidi use among urban youth—Massachusetts, March–April 1999. Morbidity and Mortality Weekly Report 1999;48(36):796–799.; Yen KL, Hechavarria E, Bostwick SB. Bidi cigarettes: an emerging threat to adolescent health. Archives Pediatrics & Adolescent Medicine 2000;154:1187–1189.; Watson CH, Polzin GM, Calafat AM, Ashley DL. Determination of the tar, nicotine, and carbon monoxide yields in the smoke of bidi cigarettes. Nicotine & Tobacco Research. 2003;5(5):747–753.
100 CDC. Tobacco Use, Access, and Exposure to Tobacco in Media Among Middle and High School Students — United States, 2004. Morbidity and Mortality Weekly Report 2005;54(12):297–301.
101 MMWR — Annual Smoking–Attributable Mortality, Years of Potential Life Lost, and Productivity Losses — United States, 1997–2001 MMWR Highlights July 1, 2005 / Vol. 54 / No. 25; Centers for Disease Control and Prevention
102 Centers for Disease Control and Prevention. "Cigarette Smoking-related Mortality" Fact Sheet. http://www.cdc.gov/tobacco/research_data/health_consequences/mortali.htm
103 American Lung Association Fact Sheet. 2000
104 U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

105 Centers for Disease Control and Prevention. Investment in Tobacco Control: State Highlights-2002. Atlanta, GA: U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2002.

106 Adult Smoking-attributable Mortality, Morbidity and Economic Costs (SAMMEC), 2004 BRFSS for prevalence and 2003 Mortality data.

107 U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

108 US Department of Health and Human Services (HHS), Reducing the Health Consequences of Smoking: 25 Years of Progress. A report of the Surgeon General, DHHS Publication No 89-8911, 1989

109 Adult Smoking-attributable Mortality, Morbidity and Economic Costs (SAMMEC), 2004 BRFSS for prevalence and 2003 Mortality data.

110 U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

111 "US Department of Health and Human Services (HHS), Reducing the Health Consequences of Smoking: 25 Years of Progress. A report of the Surgeon General, DHHS Publication No 89-8911, 1989.

112 U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

113 U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

114 Centers for Disease Control and Prevention. Smoking-attributable mortality and years of potential life lost — United States, 1990. Morbidity and Mortality Weekly Report 1993;42(33):645-8.

115 1999-2003 data; Indiana State Department of Health — Indiana State Cancer Registry, July 2006. ; Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Incidence - SEER 9 Regs Public-Use, Nov 2005 Sub (1973-2003), National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2006, based on the November 2005 submission.

116 Created by statecancerprofiles.cancer.gov on 07/26/2006.; http://statecancerprofiles.cancer.gov/cgi-bin/quickprofiles/profile.pl?18&047; Death data provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat. Death rates are age-adjusted to the 2000 US standard population by 5-year age groups. Population counts for denominators are based on Census populations as modified by NCI. Hispanic mortality data for the United States has been excluded for the following states: Connecticut, Louisiana, Maine, Maryland, Mississippi, New Hampshire, New York, North Dakota, Oklahoma, Vermont, and Virginia.

117 1999-2003 data; Indiana State Department of Health — Indiana State Cancer Registry, June 2006. Rates are per 100,000 population age-adjusted to the 2000 U.S. Population Standard.

118 2002 Indiana Adult Tobacco Survey

119 Tauras et al, " Effects of Price and Access Laws on Teenage Smoking Initiation: A National Longitudinal Analysis.

120 Chaloupka F. and Pacula R. "An examination of gender and race differences in youth smoking responsiveness to price and tobacco control policies," National Bureau of Economic Research, 1998.

121 Campaign for Tobacco Free Kids, " State cigarettes tax rates and rankings" http://tobaccofreekids.org/research/factsheets/pdf/0097.pdf

122 Campaign for Tobacco Free Kids, "Indiana cigarette excise tax increases estimated new revenues, cost savings, and other benefits and effects". 6/1/06

123 http://www.no-smoke.org/pdf/CIA_Fundamentals.pdf

124 Americans for Nonsmoker's Rights

125 American Nonsmokers' Rights Foundation's smoke free lists and maps at http://www.no-smoke.org/goingsmokefree.php?dp=d13|p140

126 2004-2005 ITPC community-based partnership applications-top five employers by number of employees per county collected in October 2003; 2006-2007 ITPC partnership applications-top five/ten employers collected in May 2005. 2005 data does not include Ohio and Kosciusko counties.

127 State-specific trends in smoke free workplace policy coverage. The Current Population Survey Tobacco Use Supplement, 1993 to 1999 National Cancer Institute.

128 2006-2007 ITPC partnership applications-top five/ten employers collected in May 2005. Only 29 counties, representing 95% of the population are eligible for these g rants therefore, only 21 counties' data is described here.

129 2002 Indiana Adult Tobacco Survey

130 2004 Indiana Adult Tobacco Survey; Centers for Disease Control and Prevention. "Cigarette smoking among adults-United States, 1991-2001. MMWR 2002; 51 (29): 642.

131 Fiore MC et al. Treating Tobacco Use Dependence: Clinical Practice Guidelines. Rockville, MD:U.S. Department of Health and Human Services, Public Health Service; 2000.

132 Hopkins DP et al. Task Force on Community Preventive Services. American Journal of Preventive Medicine 2001; 20(2 suppl): 16-66.

133 2006-2007 ITPC partnership applications-top five/ten employers collected in May 2005. Only 29 counties, representing 95% of the population are eligible for these g rants therefore, only 21 counties' data is described here.

134 http://www.tobaccofreekids.org/reports/fda/summary.shtml

135 Kozlowski LT, Pillitteri JS. Beliefs about "Light" and "Ultra Light" cigarette: an overview of early efforts and published research. Tobacco Control 2001; 10 (suppl I): i12-16.

136 Thun MS, Burns DM. Health impact of "reduced yield" cigarettes: a critical assessment of the epidemiological evidence. Tobacco Control 2001; 10 (suppl I): i4-11.

137 U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004

138 Wakefield, M, et al., "Changes at the point of purchase for tobacco following the 1999 tobacco billboard advertising ban." University of Illinois at Chicago. Research Paper Series, No. 4, July 2000.
139 2004 Indiana Youth Tobacco Survey.
140 Residential Smoking Fires and Casualties, National Fire Data Center, part of the Federal Emergency Management Agency's (FEMA) U.S. Fire Administration, based on data 2002
141 http://www.gasp.org/firesafe.html